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ABSTRACT

The National Institute of Child Health and Human Development (NICHD) Study of Early Child Care is an ongoing, prospective, 3-year longitudinal study of over 1,300 full-term healthy infants and families from 10 sites across the United States. While the sample is not nationally representative, the subjects come from major regions of the country: the East Coast, the West Coast, the Mid-West, the North, and the South. They come from urban and from rural settings, and include minorities as well as single-parent and two-parent families. The study examines the concurrent, long-term, and cumulative influences of variations in early child care experiences on the cognitive, linguistic, social, emotional, and physical development of infants and toddlers. The study design takes into account the complex interactions among characteristics of the family and home, of the child care environments, and of the child. Subject recruitment started in January 1991, and data collection was scheduled to end at the beginning of 1995. Data collection involved periodic telephone calls to families beginning at 3 months and home visits, child care center visits, or laboratory assessments at 1, 6, 15, 24, and 36 months. This document is volume 3 of a 5-volume operations manual that explains, in 29 chapters, the procedures used in conducting the NICHD study. Volume 3 consists of chapters 13 through 19. Chapter 13 provides instructions for conducting follow-up telephone interviews at 13 and 23 months. Subsequent chapters mostly address the 15-month visits and assessments. Chapter 14 presents an overview of the visits to the child's home and child care center, and laboratory assessments at 15 months. Chapter 15 provides information on conducting home visits, instructions for conducting a home environment inventory, procedures for videotaping mother-child interactions, information on standardized interviews and questionnaires, and procedures to use when the subject mother and child are not living in the same household. Instructions for conducting visits with fathers are given in chapter 16. Chapter 17 provides instructions for: (1) conducting the 15-month laboratory visit; (2) observing and coding children's solitary play; (3) conducting the Strange Situation Procedure; (4) administering the Bayley Scales of Infant Development; and (5) measuring children's physical growth. The procedure for visiting subject children's child care centers is explained in chapter 18. Chapter 19 presents instructions on making follow-up telephone calls at 18 and 21 months.

(BC)

ED 403 985

NICHD Study of Early Child Care

VOLUME III

*13 Month Manual
15 Month Manuals*



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Chapter 13

ADMINISTRATION MANUAL FOR THE 13 AND 23-MONTH PHONE INTERVIEW

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Chapter 13

ADMINISTRATION MANUAL FOR THE 13 AND 23-MONTH PHONE INTERVIEW

I. PURPOSE OF THE MANUAL

This manual provides specific information about the questions included in the 13 and 23-month phone interview. In addition, this manual serves as the archival description of the way in which these phone interview data were collected. Many of these procedures are identical to those implemented for the follow-up phone contacts (the 3-, 9-, 12-, etc. month calls). It is modelled on the 5-month call developed by Deborah Phillips.

This manual will be modified if necessary during training and data collection. Any suggestions for additions or amendments should be addressed to Deborah Vandell at the Wisconsin site, Deborah Phillips at the Virginia Site and Bonnie Knoke at the Data Coordinating Unit.

If you have a question about any aspect of these calls, send a computerized mail message to Deborah Phillips and the Data Center. The questions and their responses will be sent to ALL sites.

As a prelude to studying this manual, we recommend that each caller review the information about standardized interviewing techniques contained in the home visit manuals.

II. OVERVIEW OF THE INTERVIEW

The 13 and 23-month telephone contact serves several purposes. First, it is used to obtain current child care information. In these cases, "current" means that the data for these calls need to reflect the target child's child care arrangements (or lack thereof) at 14 months and 24 months. THESE CALLS ARE INTENDED TO REFLECT THE CHILD CARE ARRANGEMENT THAT IS OBSERVED, IN CASES WHERE THERE IS OBSERVABLE CARE. IF YOU HAVE MADE A PRIOR CALL THAT DOES NOT CAPTURE THE OBSERVABLE ARRANGEMENT (I.E. AT THE HOME VISIT YOU LEARN THAT THE FAMILY HAS SWITCHED FROM THE GRANDMOTHER TO A FAMILY CARE DAY CARE HOME), THEN YOU MUST REPEAT THIS CALL, FROM START TO FINISH.

Second, it is used to determine whether, for children in child care, any of their current arrangements fit the criteria for "primary child care arrangements" that we will observe at 15 and 24-months.

Third, it is used to obtain information on changes in child care arrangements since the 12 or 21-month follow-up phone call.

Fourth, it may be used to schedule the 15 and 24-month home and lab visits. Although the manual makes the assumption that the 13 and 23 month caller will schedule the home, lab, and child care visits, sites are permitted to adjust this procedure to meet their needs. For example, sites may choose to let their home visitors (RAs) schedule these visits in a separate call.

Just be sure not to overburden the families with too many extra phone calls and keep the data collection within the windows. It is important, however, that these schedulers use the language from the scripts in the 13/23-month (see pgs 68 - 69 in this manual) calls when describing the relevant assessments.

Fifth, at 23 months it is used to obtain information about the number of hours mothers are working. This information is used to determine if the Job Experience questionnaire is placed in the questionnaire packet left with the mother at the 24-month home visit. The 23 month phone caller prepares the questionnaire packet for the 24 month home visit.

There are several possible outcomes of this interview:

1. CHILD is not currently in any form of child care ("no" to Question 14); the mother is currently not working or going to school ("no" to Question 16); and she does not expect to be using regular care, working, or going to school at the time of the child care assessment ("no" to Questions 15 and 17), or to change arrangements before the next child care assessment ("no" to Question 45).

In this case, you will schedule the 15 and 24-month home and lab visits and there will be no child care visit at 15 or 24-months (whichever applies).

2. CHILD is in some regular child care ("yes" to Question 14, or "yes" to Question 16 and you learn that mother takes care of CHILD at home, or takes the child to work, or does actually

have some other form of regular care), but it does not fit our criteria as a Primary Child Care Arrangement for a 15 or 24-month child care visit. If the mother does not expect to change child care by the time of the next child care assessment ("no" to Question 45), you will schedule the 15 or 24-month home and lab visits and there will be no child care visit at 15 or 24-months (whichever applies).

If the mother does expect to change child care within the next two months (by the time the child is 15 or 24-months old, see 4, below.

3. CHILD is in some regular child care ("yes" to Question 14, or "yes" to Question 16 and you learn that mother takes care of CHILD at home, or takes the child to work, or does actually have some other form of regular care), and it does fit our criteria as a Primary Child Care Arrangement for a 15 or 24-month child care visit.

In this case, you will need to follow the script in Part 5 to determine the primary child care arrangement and set in motion the process of contacting the caregiver about the visit. This can go one of two ways:

(a) Either the mother gives you permission to contact the provider directly, or

(b) She wants to contact the provider first, in which case you will need to re-contact the mother to find out about the

outcome of her contact prior to making a direct caregiver contact.

You will also schedule the 15 or 24-month home and lab visits.

4. CHILD is not currently in any form of child care ("no" to Question 14); the mother is currently not working or going to school ("no" to Question 16); BUT the mother does expect to be using regular care, working, or going to school by the time of the next child care assessment ("yes" to Questions 15 and 17), OR she expects to change her child care arrangements by the next child care assessment ("yes" to Question 45).

In these cases, you will obtain the information about what the mother plans to be using for child care (see Question 46) and should have this information handy when you make the call-back. You then need to schedule a call-back to the mother at the time that her new arrangement is in place (but no later than 15 mo, 0 days or 24 mo, 0 days), approximately 3 weeks after this call, and redo the entire interview. This repeat interview will then serve as the data from which to determine whether to conduct a 15 or 24-month child care visit. DO NOT SEND THE MARK-SENSE FORMS FROM THE FIRST 13 or 23-MONTH CALL TO THE DATA CENTER. Send ONLY the second interview to the Data Center. However, we recommend that you schedule the 15 or 24-month home and lab visits after the first interview.

PLEASE NOTE: Your ultimate goal is to assure that observable child-care arrangements are assessed prior to the end of the allowable windows (16 mo or 25 mo 0 days with exception periods extending to 19 mo or 29 mo 0 days). Section III.A. describes the minimum number of required calls, and procedures for repeat attempts to reach the families. You will need to adapt these procedures for individual families. For example, some families may tell you that they are starting a new arrangement at 14 months, 2 weeks, but you learn that the switch has been delayed another week. In this case, you will need to make a second, call-back appointment.

Sometimes a family will start to change child care WITHIN the windows for data collection. If you are aware of this change/start-up in advance you may have a choice about which child care to observe. Please use the following guidelines in this situation.

(a) Observe the "old" arrangement if observing the new arrangement pushes you close to the end of the window. This will often be the case given the two week waiting period before an observation can be made.

(b) Observe the "old" arrangement if it lasted for three or more months.

(c) Observe the "new" arrangement if the "old" arrangement consists of father care, but ONLY if you are

confident that you can schedule the child care visits within the window.

For example, if you know that a family is switching child care at 15 mo, 1 week, you will need to decide whether to observe the old arrangement at 15 months (highly preferable: first visit at 14 mo, 3 weeks and second visit at 15 mo, 0 weeks) or whether to see the child in his/her new arrangement after the required two weeks of adaptation (first visit at 15 mo, 3 weeks, second visit prior to 16 mo, 0 weeks).

Sometimes you will make the call-back and discover that the family has NOT changed child care. In this case (assuming that the "old" arrangement is not going to change in the next couple of weeks), check with the mother to see if the information from the original call is still accurate (e.g., hours of care each day, address of arrangement) and schedule the child-care visit. Send the original call to the data center if nothing has changed.

We suggest that you retain the 13 and 23 month call forms until the child care visit is completed for any given target child. This will avoid situations in which initial call data are sent, and then you discover a subsequent change in arrangements that necessitates a call back, and a second set of data being sent to the Data Center.

If you want consultation on these "in-between" and unusual cases, call Deborah Phillips at the Virginia site.

III. INSTRUCTIONS FOR CALLING

The 13 month call may be started at 12 months 14 days (2 weeks prior to the child's 13 month birthday). The 23 month call may be started at 22 months 14 days. There are no close dates for these windows and there are no exception periods for these calls. Again, use these calls to schedule the 15 month and 24 month lab, home, and child care visits within their windows.

It is important for sites to make conscientious attempts to reach the mothers. By this visit, we have significant resources invested in these families; failure to contact the families results in a smaller sample. If the family has a phone but the mother has not been contacted in the first 3 days of regular attempts, efforts should be increased to include evening and weekend calls. A minimum of seven calls should be placed during the first week's attempts - three evening, two morning and two afternoon calls. If the mother is not contacted by the end of the first week of attempts, initiate the procedures outlined under What to do if you cannot reach the family by phone. If the mother is not reached by any of these means at 13 or 23 months, the same set of seven calls for contacting the mother should be repeated at 15 or 24- and then again at 16 or 25-months, if needed. Again, these particular dates are not etched in stone. Your goal is to assure that we obtain the necessary information for the childcare, home, and lab visits at 15 and 24 months, within the allowable windows.

The child's mother must be contacted and interviewed in all cases. The only exception to this rule are situations where the mother is out of phone range for some unusual reason (serving in the military, for example) and will not return until after the data collection window is closed. In this case, conduct the interview with the child's father if possible, or, if there is no father involved, with the child's primary caregiver. Indicate on the interview face sheet the relationship of the person who has been interviewed (0 = mother, 1 = father, 3 = grandmother, 4 = other adult relative, 5 = unrelated adult, 6 = sibling, 7 = other). If the mother is out of town but able to be called, she should be contacted wherever she is. Similarly, if the mother is out of contact for a short period of time (as in the hospital), arrange to call her back when she has returned home if this will be within the window for data collection.

If the mother is no longer living in the same household with the child, determine who the child's primary caregiver is. This caregiver of the child should then be contacted and informed about the study. If he or she is interested in participating, a home visit will need to be made to obtain informed consent. At this time, the information for the update can also be obtained using the appropriate alternate caregiver forms (See chapter 15.5).

With respect to the 15 month lab visit, if you find during this call that the primary caregiver has changed, you must determine who is the current caregiver and what their past relationship has been with the child. If the current caregiver is someone who has:

(a) lived with the child more than 2 months

OR

(b) has had frequent interaction with the child in the past (at least weekly),

...then we will do the entire protocol with that caregiver, including the Strange Situation. If they have not had weekly contact in the past and/or have not had primary care of the child for the last 2 months, then everything in the protocol will be conducted with this caregiver except the Strange Situation. You can get this information by asking questions like the following:

When did you assume primary/major care of the child?

What was your relationship to the child before this time?

Did you live with the child?

Did you see the child on a regular basis, at least once a week?

Did you take care of the child at least once a week?

Please make a special note of any cases where the primary caregiver is no longer the mother, and indicate whether the lab should or should not include the Strange Situation for this

child/caregiver dyad. COMMUNICATE THIS INFORMATION TO THE 15-MONTH LAB TEAM AND SCHEDULER. If you have any questions about this procedure for non-maternal caregivers, please contact Sue Spieker at (206) 543-8453 or Martha Cox at (704) 438-6532.

A. When to make the calls

The window for making the 13 or 23-month calls to the family begins when the child is 12.5 or 22.5 months. You do not need to start making the calls at 12.5 or 22.5 months. Again, use your best judgment about what is going to enable you to schedule all of the visits for each age group. If the mother is not reached, a minimum of seven calls should be attempted (consisting of at least three calls during the evening, two calls during the morning, and two calls during the evening). If the phone has been disconnected, the number is changed to an unlisted one, the family does not have a phone, or if there is no answer, follow the procedures outlined in Subsection E, "What to do if you cannot reach the family by phone."

If all of the procedures fail, wait until the child's 15 or 24-month birthday and repeat the call sequence of a minimum of seven calls. Repeat at the 16 or 25-month birthday if necessary.

B. What to do if you cannot complete the interview in a single call

Families with young children have to cope with a lot of interruptions. If the interview cannot be completed at one time, arrange a specific time to call back before the end of the following day. Thus, the second call should be within 36 hours of the first call. If this is possible, the second interview can proceed from the point where the first interview left off. If more than 36 hours elapse between calls, start the interview over at the beginning. Say something like, "I'm going to start at the beginning to be sure we haven't forgotten anything," and use confirmatory language (e.g., "You are using regular child care?") for the repeat questions.

C. How to leave a message

If you reach the family's home but are unable to talk with the mother, leave a specific message, including a time when you will call back. A suggested message to leave with another person follows.

"This is YOUR NAME from the NICHD Study of Early Child Care at the University of _____. We visited with MOTHER'S NAME about ____ months ago, and I am calling to see how she and CHILD are doing. She can reach me at PHONE NUMBER and DAYS/TIMES. I know she's very busy so

I'll try to reach her again. Do you know of a good time for me to call? Thank you." (Record date and time.)

D. An alternative message for an answering machine

"This is YOUR NAME from the NICHD Study of Early Child Care at the University of _____ calling for MOTHER'S NAME. We visited with you in MONTH, and I am calling to see how you and CHILD are doing. You can reach me at PHONE NUMBER and DAYS/TIMES, and I'll call back DAY/TIME. Thanks."

E. What to do if you cannot reach the family by phone

If the family does not have a phone, their phone is disconnected, their number has been changed to an unlisted one, or after a week of trying at all times of day and evening you have not contacted the family, special efforts must be made to reach the mother. The following steps are recommended:

1. Call work numbers if available. Unless parents have explicitly asked you not to call them at work, call the work numbers for either or both parents to arrange a convenient time to conduct the interview.
2. Make a home visit. When possible, the most effective approach to contacting a hard-to-reach family is for a project staff member who is acquainted with the mother to stop by the family's home. Often, people will not

have moved if their phones are disconnected or changed to an unlisted number. The home visit should always be carried out by someone who has met the family, and preferably someone who has been to the home before (the 6-month home visitor, for example). If the family has no phone, the interview can be carried out in person, or an alternate arrangement can be made for the interviewer to collect the information from the mother. If no one is at home but it looks as though the mother still lives there, leave a letter or card asking her to contact the project office. Be sure to let her know she can call collect.

3. Call the family's alternate contacts. Alternative phone numbers which are obtained in the hospital and/or at 1 month, and which are updated at each contact point, are useful primarily for obtaining new addresses and phone numbers for study families. Leaving messages at the homes of alternative contacts is generally not productive, although it can be tried. Asking alternative contacts to go and get the mother while you wait on the telephone is an imposition, and is not recommended. If the alternative contact can provide a new phone number or address, follow up on that by calling or making a home visit.

4. Send a letter with the project phone number and a return postcard to the family's last known address.
(Use sample letter included the 15- or 24-month Appendix.) This prompt is often enough to encourage mothers to call you, or to send you their new address or phone number. Then you can follow up with a phone call or home visit. Be sure to let the mother know she can call you collect. Mark the envelope Address Correction Requested in order to receive a new address.
5. Call directory information in surrounding areas. The family may have moved nearby and still have a published phone number.
6. Check with the post office. Provide the family's last known address to the post office and ask for the newest address for the family. The post office will charge \$1.00 per name to give the most recent forwarding address.

F. What to do if the mother says she no longer wishes to participate in the study

When a mother tells you she wishes to withdraw from participation, ask "If you don't mind, can you tell me why you

don't want to continue?" Very politely, and without being insistent or coercive, try to reassure the mother.

If she says she's too busy, having another baby, going back to work, or just feeling overwhelmed, say

"Yes, you must be really busy, especially with all these new demands on your time and energy. We do our best to make things as easy as possible for you. There are no more than two visits per year, and we like to schedule them at your convenience. We can work around the other demands on your time."

If she still feels this is not a good time to be in the study, say

"Would you prefer for us to wait and call you again in a few months?"

The regular phone calls will then continue to be made. Possibly the family could then be observed at 24, 36 months.

If she says her husband/partner doesn't want her to continue, say

"What does he seem to be concerned about?"

Then listen. Acknowledge the mother's concerns. When she is done and leaves time for you, provide supportive information, and ask

"Would you like me or SITE P.I. to call him and talk with him about our study? We would be more than happy to speak with him."

Arrange a time to call if this would be helpful.

If mother continues to say she wants to withdraw, say,
"I'm sorry you feel you cannot continue. We would very much like BABY to have the opportunity to participate in what we think is a very important study. But I certainly understand your feelings. If you change your mind, please call us. Again, our phone number is _____."

Fill out the form for recording dropouts and send it to the Data Center.

G. What to do if the mother refuses to schedule one of the three visits: child care, home, lab

When a mother tells you she cannot participate in one of the visits, ask "If you don't mind, can you tell me why you don't want to participate in the home/playroom/child-care visit?" Very politely, and without being insistent or coercive, try to reassure the mother.

See specific instructions for F above.

It is possible, for example, that the mother is uncomfortable with being video-taped at home or in the lab.

Reassure her that the data will be completely confidential and that no names are included on the tapes, etc. If she remains uncomfortable, you may eliminate this portion of the visit and retain the rest. Some data is always better than no data. Also, it is crucial that we keep these families involved and invested in the study. If we are quick to eliminate an entire visit, then we send a signal that partial participation is okay.

Be sure to inquire about helping out with transportation and babysitting.

Some sites may also have a set of mothers who have participated in each assessment who are willing to talk with other mothers; sometimes the reassuring voice of a participant is exactly what is needed. Of course, you would FIRST need to ask the reluctant mother if she would like to talk to another participating mother and, if yes, does she mind if you give out her phone number. THESE COMMUNICATIONS MUST BE KEPT CONFIDENTIAL. One mother is calling another mother -- no names involved.

However, if the mother insists that she cannot participate in one of the visits (see H below concerning the child care visit), then say *"I'm sorry you feel you cannot be part of the home/playroom/child-care visit. We would very much like CHILD to have the opportunity to participate in what we think is a very important study. But I certainly understand your feelings. If*

you change your mind, please call us. Again, our phone number is _____."

H. What to do if the mother says the child care provider will not participate in the study

"What does she/he seem to be concerned about?"

Then listen. Acknowledge the provider's concerns. When she is done and leaves time for you, provide supportive information, and say:

"Sometimes it helps a lot for us to talk to the provider and to answer (his/her) questions. Do you mind if we do this?"

IF NO, follow procedures for contacting the provider directly.

IF YES, ask *"Can you tell us a little about why you don't want us to call your provider?"*

Try to address the mother's concerns, but don't be so persistent as to jeopardize the mother's continuing participation in the study.

IV. RECORDING CALLS

The form labeled RECORD OF CALLS (Form 10C, Page 3) is for use at sites to keep track of all attempts to reach a mother. Every time the caller attempts to contact the mother, the date and time should be recorded and the result coded according to the codes listed at the bottom of the sheet. The interviewer's code

or initials should also be marked on this sheet so that if more than one caller is trying to reach the mother, each one will know who has already left messages with the family. Any special situations should also be recorded on the reverse of this form. The Record of Calls is retained at the site in the family's confidential folder.

V. FORMAT OF THE PHONE UPDATE INTERVIEW

Every interviewer should become thoroughly familiar with the format, layout, and questions of the interview. Because of the many different situations we expect to encounter during this study, the questions have been written to try to cover a great variety of responses.

The interview consists of two sets of forms: (1) forms for recording information - the FACE SHEET, RECORD OF CALLS, CURRENT CHILD CARE GRID, INFORMATION SHEET FOR 15 and 24-MONTH CHILD CARE OBSERVER, INFORMATION FOR 15 and 24-MONTH LAB VISIT, AND INFORMATION FOR 15 and 24-MONTH HOME VISIT, and (2) the actual 13 and 23-month interview and script.

Within each section of the interview, there are a number of choice points when the interviewer must skip over particular questions or sets of questions because they are not relevant to a particular situation. It is important that each caller be completely at ease with these choice points so that the interview can proceed smoothly and keep the mother unaware of the many

coding decisions and question selection decisions the interviewer is making.

The conventions followed in this interview protocol are:

1. The directions to the interviewer that are not intended to be read to the mother are printed in ALL CAPITAL LETTERS. The questions and comments to be read to mothers are printed in upper and lower case type.
2. The interviewer is expected to continue to the next question unless instructed otherwise by a GO TO or choice point instruction.
3. Questions that must fit more than one situation are worded so that the choices between two wordings are in parentheses. Example: Last time we talked you (were/were not) going to school. The interviewer is expected to choose the correct wording for the particular situation, not read both options. This requires that the interviewer have the questions clearly in mind, understand the different possible situations to which they refer, and have information about the family available.
4. Questions in which a person's name (or other specific information) is to be used indicate the missing information in capital letters, as, for example: Has CHILD had any ear infections? The question should be read as, Has Samuel had any ear infections?

VI. MARKING THE FORMS

The mark-sense forms used for the interview must be filled in carefully. Use a #2 pencil and be sure to blacken the entire space to indicate the mother's response. Whenever there are two columns of numbers, as for month and day, for example, mark both columns. If your response requires only one digit, mark 0 in the first column.

For example, to record a date of March, 1992:

MONTH	YEAR
<u>0 3</u>	19 <u>9 2</u>
- 0	0 0
1 1	1 1
2 -	2 -
3 3	3 3
4 4	4 4
5 5	5 5
6 6	6 6
7 7	7 7
8 8	8 8
9 9	- 9

Write the date in numerals on the top line, then mark the corresponding digits in the mark-sense columns below.

VII. INTERVIEW SCRIPT

The 13 and 23-MONTH TELEPHONE INTERVIEW will be used at 2 timepoints. It is essential that the boxes indicating the correct time point be marked at the beginning of the phone call. This script contains all of the introductory information you need to explain to the mother what is going to happen next. At the

beginning of the interview, you may also find it helpful to add some informal conversation with the mother to make her feel comfortable, but do not spend too much time chatting before getting down to work. The mother appreciates your friendliness but will also appreciate not being kept on the phone too long.

Once you begin the questions, they must be read exactly as they are written, with two exceptions: (1) You will have the occasional situation where the information requested is obvious or already known to the interviewer. In these cases, the interviewer may reword the question as a statement, confirming with the mother that the information obtained previously is accurate. (2) The use of the term "arrangement" seems too formal for the type of care being discussed. This is likely to happen with father care or when mothers are child care providers. In these situations feel free to substitute language such as, "How many hours a week does your husband take care of Sam?" For a few questions (e.g., Q39), alternative wordings have been provided.

Mothers have different ways of responding to interview questions. Some are very precise and specific, but others tend to give vague responses or answer in general ways that are not codable. You can encourage mothers to be more specific by enlisting them as partners in the process of data collection. For example, if a mother responds to the question,

"How many hours a week do you work?"

by saying

"15 or 20 hours."

you can say,

"I need to record a specific number of hours. Please give me your best estimate of the number of hours you work in a typical week."

The next time the mother responds with a range of numbers instead of a single answer, follow the same procedure. Usually after two reminders, mothers will understand the requirements of the interview and begin to give you codable responses without prompting.

Finally, this interview requires some flexibility in wording, especially when obtaining the information about current care arrangements and completing the grid (questions 26-37), given the wide range of possible responses. The important thing to keep in mind is that you need to get all of the information requested to complete the grid. You will not always need to ask each question. For example, if you know that the mother is the child care provider, you do not need to ask about the sex of the provider. Use common sense!

VIII. INTERVIEWING TECHNIQUES

Be sure to read all questions exactly as they are worded. If the wording seems awkward to you, practice saying the questions aloud until you feel comfortable with them.

On some occasions, mothers may volunteer information during one part of the interview that you will ask them for later. Remember what they have said, but do not flip through the interview pages to record that information. Instead, when you come to the relevant section, confirm the information you have received and ask, *"Is there anything else?"* For example, after asking the mother the first question about use of regular child care, she may volunteer that she takes CHILD to a day care center. Then, when you get to Question 26 you can say, *"You mentioned that you take CHILD to a day care center. Who takes care of CHILD there?"* But don't forget to probe for additional arrangements. Whenever you are confirming information with the mother, use the wording of the question as written to the greatest extent possible. It is essential that you cover the content of every question. Do not assume information without confirming it, even if it seems self-evident.

Because the interview cannot exactly fit every possible situation for all the mothers in the study, there will at times be questions that seem to you inappropriate. In these unusual cases, you can say something like, *"The next question asks..."* Done politely and without belittling the question, this approach lets the mother know you are attuned to her individual situation, but also that you have a job to do and you take it seriously.

Do not interpret or reword questions. If a mother asks for clarification of a question or word, try repeating the question,

perhaps with a slight change in intonation. Sometimes mothers may ask the meaning of a question that has a set of multiple choice answers. In this case, you can read her the options so she can select one of the choices.

IX. PREPARING THE MOTHER FOR INITIAL CONTACT WITH PROVIDER

During the phone call with the mother, tell the mother that you wish to visit and observe the child in his/her child care arrangement; tell her in general the purpose of the observation, what you hope to find out, and how you will do it. Usually, you will then ask the mother's permission to contact the care provider (the program director or the direct child care provider) directly about the visit. In some cases, though, it may be the better part of valor for the mother to approach the care provider first. Use your judgment; the important thing is to obtain the consent for the visit -- whatever it takes. If she wants to, the mother can mention to the caregiver that we will be calling him/her, but not seek his/her permission to visit. Alternatively, the mother may want to handle setting up and scheduling the visit herself. Or, finally, what may work best is for the mother just to give you the provider's name and for you to take it from there.

If the mother opts to be the person to contact the caregiver, you will schedule a call-back (as soon as possible,

but no more than 10 days after the initial call) and inquire about her contact with the provider.

Successful contact: Thank the mother for her assistance and proceed to provider contact.

Unsuccessful contact: In some cases, the provider will tell the mother that he/she does not want to be contacted by the research team. Try to find out why this has occurred. In some instances (e.g., the mother thinks the provider is wavering), you may deem it appropriate to contact the provider anyway, but be sure to ask the mother's permission to do this. In other instances, both mother and provider will be adamant about refusing the child care visit. If the child does not have a secondary arrangement in which he/she is enrolled for at least 10 hours a week, we have a missing child care observation. If there is an appropriate secondary arrangement, ask the mother if we can repeat the recruitment process for this provider.

TROUBLE SHOOTING: If the mother seems reluctant to talk to the provider about the visit (or to have you contact the provider) or to have the child observed in child care, ask her why. If possible, use one of the following suggestions to address specific concerns:

A. The mother feels the child has not been in the arrangement long enough. Explain we do not observe a child

unless he/she has been in the new arrangement for at least 2 weeks. Our experience has shown us that for our purposes, this seems to be enough time for both the child and caregivers to adjust to a new situation.

B. The mother feels the observations would be asking too much of the provider. If the mother is concerned because the observer could be intrusive or disruptive, explain that we will describe the study in detail to the provider, and arrange times for the visits that are convenient to the provider. Mention that we tell the provider not to make any special arrangements, and that we will respect the routines and responsibilities of the caregivers during the visits. Emphasize that after we explain the study to the provider, we ask for the provider's separate consent to participate in the study.

C. The mother feels the study would not be of enough interest to the provider. Explain that we will send the provider information about the study before calling, and emphasize that observing the child when he/she is away from the mother is important to our understanding of how a child develops. We will explain to the provider that his/her participation is important and valued. Mention that the

provider will be asked for separate consent after the study has been explained by the project staff.

D. The mother feels the caregiver would be reluctant to have an "outsider" judge the quality of the caregiving environment. Explain that any observations are confidential and will only be shared with the project staff (except in cases of child abuse). If the mother inquires now or at any time if we will report back to her about the caregiving arrangement, tell her "No, our observations are confidential, just as all the information that you give us is confidential. Of course, overall study conclusions will be shared with you and any interested caregiver."

E. The mother suggests that she get the provider's permission before we call. Accept her suggestion, and advise her in doing so to reassure the caregiver of the unobtrusiveness of the researcher, the importance of the study, and so on.

No contact: If the mother has not contacted the provider during the 10 days after the phone call, ask her why. If possible, use one of the following suggestions to address specific concerns:

A. The mother simply forgot to contact the provider.

Emphasize that it is very important that she do this in the next day or so, in order for us to have time to contact the provider and schedule the visit. If after three contacts by the project staff the mother still has not contacted the provider, probe as to why, and follow troubleshooting suggestions below (B. and C.).

B. The mother has changed her mind about consenting to the caregiver visits.

1. If the mother seems ambivalent, probe for the reasons for her reluctance. See troubleshooting suggestions for the 3-month call to handle concerns.

2. If the mother is definite in her refusal and does not want to discuss her decision, we have a missing child care observation.

3. If the mother is willing to discuss her refusal, use the trouble shooting suggestions for the 3-month phone call. If she remains unswayed by troubleshooting suggestions, we have a missing child care observation.

C. The mother suggests that we make the initial contact ourselves. We agree to do this and follow provider contact procedures.

X. PRIMARY CHILD CARE ARRANGEMENT: DECISION RULES

Each site is provided with two copies of this page summarizing the decision rules. Post a copy by each phone from which the 13 and 23-month calls will be made.

PRIMARY CHILD CARE ARRANGEMENT:DECISION RULES

Child must be in the primary arrangement 10 hours a week or more (Q32), typically awake for 3 hours on days used (Q33), and must have been enrolled for at least 2 weeks prior to the child care visit (Q36 gets age in months when enrolled. We will confirm the 2-week requirement when the child care visit is scheduled).

If mom cares for child at home (Q19[1]), other non-sibs who live in another household must be present 20 hours per week (YES to Q20, Q21, and Q22).

If mom takes child to work (Q19[2]), she must work in a child care center (Q23[1]) or another adult must regularly spend 10 hours per week with baby as a sitter (YES to Q25).

When multiple arrangements meet these criteria: (Use these decision rules hierarchically.)

1. Use arrangement with most hours of care per week (see Q32), including only those arrangements where child is typically awake for at least 3 hours.
2. If comparable hours (plus or minus 5 hours per week), use most "formal" arrangement: group program, home-based program, non-relative, relative other than father, father (see Q26).
3. If comparable hours in same type of arrangement, use arrangement in which child has been enrolled the longest (see Q36).
4. If all else is equal, use morning arrangement, unless BABY has been enrolled in afternoon arrangement for at least one month longer (see Q34).
5. If all else equal, pick primary arrangement randomly.

XI. FACE SHEET

The face sheet for the telephone contact (labeled INFORMATION FOR 13 and 23-MONTH TELEPHONE INTERVIEW) is for use by the project staff at each site to help keep track of the information needed in the interview. This sheet is not to be sent to the Data Center. It should be filed in the family's confidential file.

Before calling, fill in all the indicated information on the face sheet. Use the information collected at the most recent contact to fill in these pages. Also, use this information to fill in question 1 (Form 10C, Page 1 of the interview) before calling.

During the call, you will get information on changes in addresses, phone numbers, and contact persons. Write this new information on the face sheet.

When making calls, record the date/time and results of each call on (Form 10C) Page 3 (labeled RECORD OF CALLS). This form should not be sent to the DCC; it should be filed in the family's folder.

At the completion of the interview, fill in page 2 of form 10B completely, with date of interview, interviewer's ID number, child's ID number and relationship code, and child's age in months.

Once the interview is completed, separate the site face sheet (Page 1 of Form 10B) and the RECORD OF CALLS (Page 3 of

Form 10C) from the interview itself and file them in the family's confidential folder. Have the interview forms checked by the site coordinator or his/her designate before they are sent to the Data Center.

XII. CURRENT CHILD CARE ARRANGEMENTS GRID (Form 10A)

Before calling, have the CURRENT CHILD CARE GRID in front of you. You will fill it in as you reach Questions 26-37 in the interview. You will rely on this form to determine whether the child is in a child care arrangement that will be observed at 15 or 24 months. This is sent to the Data Center. Be sure to fill in the ID number and indicate which age (month) data is being collected..

XIII. INFORMATION SHEETS

The 13 and 23-month telephone contact packet includes several forms (INFORMATION FOR 15 and 24-MONTH LAB VISIT, INFORMATION FOR 15 and 24-MONTH CHILD CARE OBSERVER, INFORMATION FOR 15 and 24-MONTH HOME, EXPECTED CHILD CARE AT 15 and 24 MONTHS) that are designed to prepare you for the next steps in the study, whether they involve a call-back, the 15 or 24-month home visit, the 15 or 24-month lab visit, or the scheduling of a child care visit at 15 or 24 months. These are not to be sent to the data center. They can be used to notify project staff of

upcoming appointments and are to be filed in the family's confidential file.

A. Child Care Observer

Before calling, have a CHILD CARE GRID and an INFORMATION FOR 15 and 24-MONTH CHILD CARE OBSERVER in front of you. For families who are not using or expecting to use child care at CHILD's 15 or 24-month birthday, you will fill in the child ID#, phone number, date/time of 13 or 23-month call, and interviewer; circle (2) for Primary child care arrangement; and record the date and time of the 15 or 24-month home visit(s) and the 15 or 24 month lab visit. For families who have a Primary child care arrangement, you complete all of this information, but circle (1) for Primary child care arrangement, and complete the information about the arrangement to be observed at 15 or 24 months.

For families who expect to be starting or changing child care when the CHILD is 15 or 24 months old, you will circle (3) for Primary child care arrangement, fill in the date and time of the call back on the RECORD OF CALLS form, and transfer the information about expected arrangements (Question 46 of the interview) to INFORMATION FOR 15 and 24-MONTH CHILD CARE OBSERVER for reference at the call back.

Finally, for those cases in which the mother wants to make the first contact with her care provider, you will need to write the date and time of the call back on Page 13, and give this call

a code of (4) on the RECORD OF CALLS (Form 10C), indicating the time and date to call there as well.

B. Home and Lab Visits

INFORMATION FOR THE 15 and 24-MONTH LAB VISIT (Form 14A) AND INFORMATION FOR THE 15 and 24-MONTH HOME VISIT (Form 15A) are notification sheets to help you keep track of home and lab visit information. These sheets should be filled out after the interview and may be used to coordinate these visits at your site. They are not sent to the DCC but should be kept in the family's folder.

At 24 months, the information regarding mother's work phone and whether child care will be observed is NOT recorded on the Information for the Home Visit. The 24 month home visitor is to be kept blinded about work and child care.

XIV. AFTER THE INTERVIEW

For families who are using child care that fits our criteria for observing, one of two procedures will be followed to schedule the child care visits:

1. PREFERRED: The mother gives you permission to contact the provider directly. In this case, send the mother the letter in Appendix A2 or B2, which briefly describes the child care visit.

2. The mother first contacts the provider. In this case, you will send the materials in Appendix A3 or B3 to the mother. These are: (a) a letter to the mother which briefly describes the child care visit and tells her or him what to do with the enclosures, (b) a list of points that the mother should be sure to mention to her provider when she talks to her about participating in the study, (c) a letter to the provider that the mother may or may not choose to mail or give to the provider, and (d) an enclosure for the provider letter which describes the overall study. PUT THE LETTER TO THE PROVIDER AND THE STUDY DESCRIPTION IN A SEPARATE ENVELOPE AND ENCLOSE IN THE PACKET TO THE MOTHER.

For families who are not using child care that fits our criteria for observing, proceed with the procedures for conducting the 15 or 24-month home and lab visits.

REMEMBER

BEFORE YOU CALL:

1. Complete the INFORMATION FOR 13 and 23-MONTH TELEPHONE INTERVIEW (Form 10C, page 1)
2. Transfer all information about child care arrangements to Question 1 of the 13 or 23-month Telephone Interview.
3. Know the mother's and baby's names. If your site is participating in the HHS Fathers Study, know the father's

name and whether the parents are married (so you can use "husband" or "partner" appropriately).

4. Tear out INFORMATION SHEET FOR 15 and 24-MONTH CHILD CARE OBSERVER and have a CURRENT CHILD CARE GRID available. You will be filling these in during the interview.
5. Have the decision rules for determining an observable primary child care arrangement posted by the phone and memorized.

XV. FLOWCHART OF THE INTERVIEW PROCESS

PART 1: INTRO

PART 2: STOPPED CARE?

PART 3: SICK CARE

PART 4: CURRENT CARE

PART 5: IDENTIFY PROVIDER

PART 6: SCHEDULE HOME AND LAB VISITS

PART 7: PREPARE QUESTIONNAIRE PACKET FOR HOME VISIT

PART 8: COMPLETE INFO SHEETS FOR OBSERVER

XVI. THE INTERVIEW FORMS

The following sections of this manual provide specific information about the questions included on the phone update interview. Callers should read through this section of the manual regularly to be sure they are thoroughly familiar with all coding rules and with the format of all questions and answers.

Part 1: INTRODUCTION

This section introduces you and the interview to the mother, and obtains any updated information about addresses and phone numbers. Any changes must be recorded on the INFORMATION FOR THE 13 and 23-MONTH INTERVIEW form (Form 10C, page 1).

There are three YES/NO questions on page 1 after the introduction. They pertain to unusual changes in the child's routine, separations, and other unusual circumstances. They should have been placed on page 15, when you are scheduling the lab visit.

Part 2: STOPPED CARE?

Question 1

To link this interview to the prior 12 or 21-month phone interview, we start by inquiring about changes in child care arrangements since that contact. The interviewer should have filled in any relevant information from the Fact Sheet (Form

10C, page 1), and should be prepared to remind the mother of what she said about child care at the 12 or 21-month call.

Note that there are two options for phrasing the question, corresponding to mothers who were and were not using child care at the 12 or 21-month call. Although it seems a little awkward, the interviewer must proceed, in both cases, to ask about changes. It is possible, for example, that a mother who did not use child care when the child was 12 or 21 months old started to use care at 13 and 23 months that lasted only 1 month. In this case, she would say "yes" to Question 1.

Code "yes" if any arrangement was discontinued, even if it lasted only a very brief while.

Question 2

See Question 26.

Questions 3 and 4

See Questions 30 and 31.

Question 5

See Question 32. In cases where the hours changed in the time this arrangement was used (e.g., gradual shifting from part-time to full-time care), use the most recent hours.

Questions 6 and 7

See Question 36.

Question 8

See Question 37.

Question 9

This question is designed to assess whether this was an anticipated and/or planned change in arrangements, or whether the mother was caught by surprise or affected by events beyond her control and thus HAD to change arrangements. ASK THE QUESTION AS WORDED. If the mother answers "yes" or "no", accept her answer, regardless of the following guidelines. If she is unsure and explains her situation then and only then should you use the decision rules, below, that defines "planned" vs. "unplanned". The bottom line is to go with the mother's perception of the change as planned or unplanned. Here are some examples and guidelines for cases where the mother cannot tell you if the change was planned or unplanned. If a family day care provider stops providing care, for example, this would not be a planned change. If, however, the mother decides that she does not like the provider and therefore chooses to leave, this is a planned change. Other examples of unplanned changes include, the child is asked to leave an arrangement (some centers will not tolerate "disruptive children"), the family moves to a distant part of

town unexpectedly, or another child joins the child care whom the mother dislikes and therefore she changes arrangements. Other examples of planned changes include switching from a grandparent to a center so the child can have more social interaction, changing arrangements because something more convenient or affordable is found, or changing because a friend has a baby and she decides to share care.

Part 3: SICK CARE

Ask the questions in this section only if the child was in some form of child care at the 12 or 21-month call. You can determine this from the Face Sheet (the mother indicated a child care arrangement at the 12 or 21-month call).

Questions 10 and 11

When a baby is sick, mothers often have to piece together a patchwork of care. Record one or two emergency arrangements the mother made. Question 10 has been reworded from the 5-month call which asked if CHILD had been sick on a day when the mother worked or was in school. Since mothers may use child care for any reason, we really want to know if the CHILD has been sick when the mother typically relies on child care for any reason.

Question 12

PLEASE REWORD this item to read, "In the last 2 months, have you or your (husband/partner) missed work, school, or another regularly scheduled activity because of a problem with your child care arrangement?"

Missing work means a significant amount of work. Code Yes if one parent missed a half day or more, or missed an important work obligation, such as an important meeting or appointment.

Question 13

Ask as an open-ended question and code if possible. Read the list of possible problems if the mother does not immediately volunteer a codable response. Only ONE response is allowed.

Part 4: CURRENT CARE

This section obtains information about the family's current reliance or lack of reliance on child care. Families who are using child care will fall into two groups: (1) those for whom at least one arrangement meets the decision criteria for observing the child in care at 15 or 24 months, and (2) those for whom none of the arrangements used meet the decision criteria. Recall that we are collecting the child care information on both types of families.

This is also the section where the CURRENT CHILD CARE GRID is completed (see Questions 26-37).

Question 14

The major purpose of this interview is to get information about the family's regular child care arrangements. Regular means that the mother has some standing arrangement with another person to care for the child at a specified time every week. This may include short periods of babysitting. For example, if the mother has a regular evening or Saturday afternoon when her husband/partner is expected to be responsible for the baby, this is a regular arrangement. Also, if the mother leaves the baby with her mother every Thursday afternoon, or expects an older sibling to be responsible for the baby from 4:00 to 5:00 every day, these count as regular arrangements. If she occasionally hires a sitter to go out in the evening, this is not a regular arrangement. Nor are arrangements that occur on a non-weekly basis. For example, if a mother-in-law comes one week a month to care for the child, we are not considering this to be child care. Be careful not to confuse regular with the criteria for scheduling a child care observation. It is entirely possible for a family to have a regular arrangement that does not fit the criteria for observing. For example, a sitter who comes 2 days a week for 4 hours each day does not meet the minimum of 10 hours a week for scheduling an observation.

Question 15

PLEASE REWORD this item to capture the following periods of time:

For 15 months, 14-16 months

For 24 months, 24-25 months

For 36 months, 35-37 months

You should say, "Do you expect to start using regular care (to be working for pay or going to school) between your child's 14 and 16 month birthdays?"

Because we are calling the families at 13 and 23-months, but making our child care observations at 15 and 24-months, it is possible that a few families will be starting child care between this call and the child's 15 or 24-month birthday. This question is designed to flag these families, and is asked only if the family is not currently using child care (NO to question 14). If the mother responds "yes" to this question, skip to Question 46, which gets information about her child care plans, and then SCHEDULE A CALL-BACK in approximately 3 weeks.

Question 16

Some mothers may not consider themselves to be using regular child care and so answer "no" to question 14. But, in fact, they are working or going to school, in which case we want to know what they are doing about child care. If a "yes" answer is

given, skip to question 18 (hours of work/school) and then inquire about child care (question 19).

Question 17

PLEASE REWORD this item to capture the following periods of time:

For 15 months, 14-16 months

For 24 months, 24-25 months

For 36 months, 35-37 months

You should say, "Do you expect to start using regular care (to be working for pay or going to school) between your child's 14 and 16 month birthdays?"

This is similar to Question 15. Some mothers will resume work between their child's 13-(23) and 15-(24)-month birthdays, but will still answer "no" to question 15. This question assures that we will get information about how they plan to handle child care if they are returning to work in the next month. Again, if the mother responds "yes" to this question, skip to Question 46 and then SCHEDULE A CALL-BACK in approximately 3 weeks.

Question 18

This question is asked only of mothers who do not respond "yes" to question 14, but indicate that they are working now or going to school (Question 16). If the hours per week vary from

one week to the next, ask the mother how many hours she worked or went to school "last week".

Question 19

This question is asked of mothers who did not say "yes" to having a regular child care arrangement (Question 14), but who are now working or going to school ("yes" to Question 16). Ask this as an open-ended question. The mother may respond with a non-maternal child care arrangement, such as "My husband takes care of the child." Code this as "3 Other" and complete Question 26. Similarly, the mother may say, "Oh, my mom comes over and watches CHILD." Code this as "3 other" and complete Question 26. But, the mother may indicate that she takes care of the baby while she is working and would have probably said "no" to Question 14. If this is the case, two options are possible. The mother may work at home and care for the child at the same time (code as "1" and GO TO Question 20). This will be the case for mothers who provide family day care in their own home, as well as for mothers who are, for example, private consultants and who work out of their home and decide not to hire anyone else to provide child care. Alternatively, the mother may take the child to her out-of-home job and either watch the child full time or rely on someone at the worksite to watch the child at least part time (code as "2" and GO TO Question 23).

Questions 20, 21, and 23

If the mother is taking care of her child while working/studying at home, the three conditions described in questions 20, 21, and 23 MUST BE MET before we will observe this arrangement as a child care arrangement. Specifically, unrelated children (Q20), who live in another household (Q21), must spend at least 20 hours per week with the mother and child in a typical week (Q23) for us to observe this as a child care arrangement. A response of "no" to any of these questions ends the interview and you move to scheduling the 15 or 24-month home and lab visits. It is important to note that some children will have siblings who live in a different household and who come to the mother's house during the day. We will NOT observe these arrangements, because we consider mother and siblings to be a primary family unit. However, if the child has a cousin who lives in a different household and comes to the mother's house during the day (20+ hours per week), we DO observe this arrangement. Basically, we consider these mothers to be family day care providers.

Questions 23, 24, and 25

If the mother takes CHILD to work with her, we will observe this as child care IF the mother is a child care worker and CHILD comes to her center (Q23[1]) OR the mother has another form of employment (Q23[2]) in which she brings CHILD to work, but some

other adult routinely watches CHILD for 10 hours a week while the mother is doing other things ("Yes" to Q25).

If the mother is a child care worker, we find out if CHILD is in her classroom (Q24). If she answers "yes", GO TO question 26 and, working with the GRID, ask if anyone else takes care of CHILD. There may be more than one child care provider for the infant classroom, for example, in which case you would code 0) mother and 7) unrelated adult (assuming the provider is unrelated) for 26. If she answers "no", GO TO question 26 and ask as worded: Who takes care of CHILD? Obviously, in both of these cases, you can code 27 as 3 and 28 as F, but 31 will vary depending upon whether only the mother, only another provider, or both provide care.

If the mother brings CHILD to work and another adult watches CHILD for 10+ hours per week (even if it is the father), GO TO question 26 to find out who this other adult is and whether he/she lives in the child's home or not. You can code 27 as "4". If the mother brings CHILD to work and the criterion for observation is not met (no other adult watches the baby for 10+ hours per week), then the interview is completed and you need to schedule the 15 or 24-month home visit.

USE OF THE GRID (Questions 26-37)

The interviewer will have the grid placed in front of him/her. All responses to Questions 26-37 are recorded on the

grid. This will greatly facilitate the process of determining whether the child is in an arrangement that meets the criteria for observing at 15 or 24 months and, in the care of multiple arrangements, which one to observe. For families with one observable arrangement, the interviewer should also complete the GRID section of the INFORMATION SHEET FOR CHILD CARE OBSERVER.

Question 26 and 27: Coding Child Care Arrangements

You will obtain this information by asking open-ended questions: Who is caring for the child? You will need to probe after the mother gives you one arrangement, to make sure that she is not forgetting to tell you about additional arrangements.

Mothers will answer the questions about child care arrangements with more conventional descriptions (babysitter, nanny, etc.). The responses on the interview form are not intended to be read to parents. Instead, they are for your use in coding the type of arrangement the parents have made for child care. Thus, if the mother says they have found a sitter, you will need to ask if the sitter is a relative, whether he or she will be coming in to their home or they will be taking CHILD to the sitter's home, and whether the sitter lives in the child's home or elsewhere.

Be sure to code all arrangements, even if some of them are informal, such as the child's father staying home until 9:00 every morning. Although many mothers will not think of this as a

child-care "arrangement", it is to us. Use Arr. 1 for the arrangement used for the most hours, Arr. 2 for the next, and Arr. 3 for the third. Do not code more than three arrangements.

If the mother begins to tell you about future plans, explain that we will be asking about this at the end of this interview (see Question 45).

It is a good idea, in the case of multiple arrangements, to let the mothers describe the situations and code the information while she is talking. Then go back and confirm the information and fill in any gaps before proceeding.

Sometimes it will be difficult to determine whether a particular situation is one or two arrangements. For example, if CHILD has a non-related sitter who comes into the child's home 3 days a week and cares only for CHILD, and who takes CHILD along with her to a different child's home for 2 days a week (thus caring for two children on these two days in the other child's home), this counts as two arrangements, as follows:

Arrangement 1: WHO? = 7) Unrelated adult
WHERE? = 1) In baby's home
LIVE IN? = No

Arrangement 2: WHO? = 7) Unrelated adult
WHERE? = 2) In someone else's home
LIVE IN? = No

This counts as two arrangements, because you are not able to give more than one response for #27 WHERE? and, therefore, could not accurately code the relevant information as one arrangement. It is also important to code this as two arrangements because you will have two different responses for Question 30 (Arrangement 1 = 00; Arrangement 2 = 01).

Similarly, the CHILD may be cared for alone by a sitter on Monday and Wednesday at the baby's home, but be joined by her 3-year-old sister on Tuesday and Thursday. Again, this would count as two arrangements, both coded as WHO? = 7, WHERE? = 1, LIVE IN? = No, but coded as 00 and 01 for Question 30.

It is also possible that some mothers who use their husbands/partners for child care will say "no" to Question 14, "yes" to Question 16, and will indicate for Question 19 that the husband/partner helps her with child care while she works (thus, Question 19 gets coded as (3) and you skip to Question 26). GO BACK TO Question 14 and score YES. You may then restate Question 26 as a statement: *"CHILD's father/your partner will care for CHILD. Where will they be? Does he live in CHILD's home?"*

Examples of probe questions to ask:

Mother's Response

"My neighbor is caring for CHILD.

Query

- 1) "Is your neighbor related to you?"
- 2) IF NO, code 6 for Q26.
- 3) IF YES, "What relation?"

- 4) "Is CHILD cared for at your neighbor's house?"
- 5) IF YES, code 2 for Q27.
- 6) IF NO, "Where is CHILD cared for?"
- 7) "Does your neighbor care for CHILD during all the hours you work?"
- 8) IF NO, "What other child care arrangement do you use?"

"My church has a nursery that I use."

- 1) "Who cares for the children in the nursery?"
- 2) "Is the nursery open during all the hours you work?"
- 3) IF NO, "What other child care arrangement do you use?"

"My husband is taking time off when I'm working."

- 1) "Does he care for CHILD at home?"
- 2) "Is he able to care for CHILD during all the hours you work?"
- 3) IF NO, "What other child care arrangement will you use?"

"I've hired a nanny."

- 1) "This is someone who comes to your home to care for CHILD?"
- 2) IF NO, "Where is CHILD cared for?"

- 3) "Is this person related to you?"
- 4) IF YES, "What relation?"
- 5) "Will the nanny live in your home?"

Questions 28 and 29

For families using child care that is not observed, Question 28 is the only source of data about gender of the caregiver. Obviously, you will use confirmatory language if you know the father or grandmother provides child care. Question 29 enables us to distinguish nannies from out-of-home providers.

Questions 30 and 31

Some mothers, particularly those who use group care, will tell you that they don't know how many other children are in the classroom, or how many people supervise her child. Ask her for an estimate. If she says she has no idea at all, leave this question blank.

The purpose of these questions is to find out how many other children are usually present when the child is in the care setting, and how many regular caregivers the child has. In a day care center record the number of children in the child's group or classroom, not the number in the whole center. In both centers and homes, the number may change during the day. Ask the mother for the typical number present during the majority of the time the child is in the setting. For example, if three kindergarten

children are cared for by the child's caregiver from 4 p.m. on, but the target child is cared for from 8:00 to 5:00, do not count these children as part of the typical group. Base the typical group on the current situation; group sizes will also change seasonally.

In counting caregivers, ask the mother for the number of different people who supervise the children on a regular basis. For example, if the child's group has a head teacher who is present all day, two assistants in the morning and two different assistants in the afternoon, the number of people supervising the children is five. If a home child care provider has a teenager or another adult who regularly assists with the children, and the caregiver's husband is in charge everyday after 4:30, the number of people supervising the children is three. Don't count music teachers, etc., who come in two times a week.

Remember that we will actually observe staff-child ratios over the course of the child care visit at 15, 24, 36 months. The responses to these questions will not serve as estimates of staff-child ratios.

Questions 32, 33, 34, and 35

These questions are intended to get at the pattern of child care as well as the total number of hours. Thirty hours divided over 3 days is a different experience for the child than 30 hours divided over 5 days. In cases where the baby's schedule changes

from week to week, ask the mother for the "most typical" situation in her opinion. We will obtain more detailed information about schedules when we do child care visits. If the word "arrangement" is awkward for the situation of the family you are interviewing, reword Question 32 to say, for example, "*How many hours a week (is CHILD/will CHILD) be cared for by your mother?*"

Question 33 is important for the determination of whether to observe CHILD in child care. If the mother says "it varies a lot", you can ask specifically if CHILD is awake 2 days a week for 3 hours a day. This will make the observations feasible. If you get an indication that you cannot count on this amount of awake time, then mark "no", and it is not an arrangement that we will observe.

For Question 34, you can mark more than one response. For example, if CHILD is in a day care center from 7 am to 6 pm every day that this center is used, then code 1 and 2 for this arrangement. If, however, CHILD goes to the center in the morning on some days and in the afternoons on others, then code as 5. Thus, "times vary" means that, for a single arrangement, the hours that CHILD spends in this arrangement are not consistent from one day to the next over the course of a week.

For Question 35, count a portion of a day as a day.

Question 36

Get the mother's best estimate if she cannot remember.

For responses in days or weeks, round up to months, e.g. 6 weeks = 2 months.

Question 37

Ask this as an open-ended question. If the mother's response clearly fits one category (e.g. *"I really wanted CHILD in her own home"* = 8), code it as such. If it could fit several categories, read the relevant categories and ask the mother to choose one (e.g., *"Only someone like Granny could really take good care of CHILD."* Ask, *"So would you say the quality of the care provider is the most important reason, or that your preference for a relative to provide care is the most important reason?"*). If the mother gives more than one answer that fits more than one category, you'll need to ask her to give you one response. Say, *"What would you say was the most important reason?"* Write in what the mother says if you code her answer as 11) Other.

Skip questions 38-41 if mother is an in-home child care provider.

Question 38

If the mother pays a daily or monthly rate, record what she tells you and later calculate a weekly rate. Do not take up interview time to make these calculations. If the mother has one

or more arrangements that you think may be free (father or grandmother, for example), you can phrase the question more as a confirmation: "And our next question is how much you pay for this care." Mothers will typically let you know if there is no cost. If they are not paying, record 00. If the mother is using multiple arrangements over the course of a week, but gives you a weekly rate, ask her to give you the amount she pays each week for each arrangement.

Question 39

If mothers are not paying for care, rephrase Question 39 as:
"Does this care include other children of yours?"

Question 40

Be sure to count children other than CHILD.

Question 41

Be sure to get information only on current support. If you know the parent is receiving free or very low cost care (from Question 38), you can confirm that situation. Responses 2, 4, 6 and 8 refer to "low-cost or free" care. Low-cost, in this context, means that the child receives subsidized care so that the parents are not paying the full cost. Some parents do not pay anything for child care. They get free care because they are fully subsidized by a government program (#2) , by their employer

(#4), or by an agency (such as a social services agency) (#6). In other cases, a relative or friend of the child will provide child care free of charge. In these cases code #8. Also, use response [8] for a family who has worked out a cooperative child-care sharing arrangement with another family and so are not paying for care. Response [3] includes mothers who are child care providers in centers that offer free or reduced-fee care to their staff. Response [7] indicates that a relative or friend is providing money to pay for child care.

If parents reply that they receive no financial help, ask, "Do you plan to claim a tax credit for child care expenses?" If the mother says yes, record the response as [9]. Some states, as well as the federal government, offer these tax credits/deductions for child care. Some mothers may say that they receive no financial help and they are not claiming a tax credit, but their employer is allowing them to set aside up to \$5,000 of her taxes before income to help pay for child care. These Dependent Care Assistance Plans are becoming increasingly common. The money that is set aside does not count as taxable income, therefore this is a form of tax subsidy for child care. Code this as [9]. Option #10 is coded when the family pays the full cost of care (no tax credit or deduction issued).

Questions 42 and 43

These questions are designed to measure the mother's satisfaction with her current child care arrangement -- not the generic type of arrangement, but the specific provider(s) that she is now using. Read the responses and ask the mother to choose ONE. For Question 43, if she says that she would not recommend to her friend that she use her provider because she does not want to share care, explain that you want to know how satisfied she is with her current arrangement, and this is one way of asking this -- you don't mean to imply that she would have to share care.

If the child is receiving care from a relative or close friend, particularly the father, this is a difficult set of questions, particularly for Question 43. In these cases, it is fine to say, *"Based on your experience, what would you say to a friend who wanted to make the same type of arrangement that you have made."*

Question 44

Write down whatever the mother says.

Questions 45 and 46

PLEASE REWORD this item to capture the following periods of time:

For 15 months, 14-16 months

For 24 months, 24-25 months

For 36 months, 35-37 months

You should say, "Do you expect to start using regular care (to be working for pay or going to school) between your child's 14 and 16 month birthdays?"

These questions will tell you if you need to schedule a call-back because the child will be in a different child care arrangement when she/he is 15, 24, 36 months old. For Question 46, see Question 26, 27, and 29, with the addition of a "don't know" code.

Part 5: IDENTIFY PROVIDER

At this point in the call, you need to determine whether the target child is in an observable child care arrangement. Some children will be in care that is not observable. You will work with the GRID and the INFORMATION SHEET FOR CHILD CARE OBSERVER for this portion of the call.

Recall that the arrangement may be made for any reason. The mother does not have to be employed or in school.

There are two basic criteria that must be met in order for a child care arrangement to be observable:

- (1) The child must be in care 10 hours a week or more
- (2) The child must be awake for 3 hours on a typical day in care in order to make the observation feasible

You will work with the GRID to determine whether any arrangements meet these criteria (see question 32 and 33), and, if so, how many of them meet the criteria.

Once you have determined the primary arrangement, you will ask the mother a series of questions while completing the INFORMATION SHEET FOR CHILD CARE OBSERVER.

Children With One Observable Arrangement

For children with one observable arrangement, this becomes the primary arrangement. You will pick up with the script, saying "As we've told you, we'd like to see CHILD is (his/her) childcare when he/she is about (15/24) months old. We would like to visit (PROVIDER: GIVE ALL IDENTIFYING INFORMATION, E.G., WHO AND WHERE FROM GRID).

You then obtain information about the name of the provider (or of the center), address, and phone numbers.

Next, you will ask when the child started using the arrangement. THIS IS IMPORTANT FOR SCHEDULING SINCE THE CHILD MUST HAVE BEEN IN THE ARRANGEMENT FOR 2 WEEKS PRIOR TO THE FIRST OBSERVATION. It does not have to be full time for 2 weeks, just 2 calendar weeks since initial enrollment.

Then you will ask about the hours each day when the child is in the primary arrangement and fill in the actual hours on the INFORMATION SHEET FOR CHILD CARE OBSERVER.

The final step involves determining whether you can contact the provider directly and, if not, making arrangements for the mother to contact the provider and for you subsequently to re-contact the mother.

For Children with Multiple Observable Arrangements

When multiple arrangements meet the two criteria for observable child care, you will need to determine which one is the primary arrangement for purposes of observation. There are five guides, which should be approached hierarchically:

- (1) Use arrangements with the most hours of care per week including only those arrangements where the child is typically awake for at least 3 hours. There is one exception to this first guide. If father care is the arrangement with the most hours and there is another observable arrangement, the other arrangement will be the primary arrangement. We will observe father care only if there is no other observable arrangement.
- (2) If comparable hours (plus or minus 5 hours per week), use most "formal" arrangement; in this order: group program, home-based program, non-relative, relative other than father, father.
- (3) If comparable hours in same type of arrangement, use arrangement in which the child has been enrolled the longest.

- (4) If all else is equal, use morning arrangement, unless the child has been enrolled in the afternoon arrangement for at least one month longer.
- (5) If all else is equal, pick the primary arrangement randomly.

Once you have determined the primary arrangement, follow the procedures outlined above under Child with One Observable Arrangement.

Special Cases

There are two special cases that count as observable care and must be considered when determining the primary arrangement.

- (1) The mother cares for the child at home (Question 19[1])
AND other non-sibs who live in another household are present 20 hours per week (YES to Questions 20, 21, and 23).
- (2) The mother takes the child to work (Question 19[2])
AND:
 - (a) She works in a child care center (Question 23[1]).
(She may or may not have her child in her classroom.)
 - OR
 - (b) Another adult regularly spends 10 hours per week with the baby as a sitter at the mother's workplace (YES to Question 25). In this case, it

must be one adult spending 10 hours or more with the child. If there are two adults who each take care of the child for 5 hours per week, this is NOT an observable arrangement. If there are two adults who each take care of the child for 10 hours or more per week, select the provider based on the criteria listed for multiple arrangements (i.e., most awake hours, provider child has known the longest, morning provider, random choice).

Part 6: SCHEDULE HOME AND LAB VISITS

This is a very important part of the procedures for the 15- and 24-month assessments. The home and lab visits may be scheduled at the conclusion of the 13- and 23-month calls, as planned. However, they may also be made in separate calls. In this latter case, it is important to use the language in the following scripts when describing the content of the various home and lab visits. The scheduler needs to describe briefly both visits and set up the dates and times for these visits (see windows and ideal times, below.)

15 Month Lab Visit	The Week Before 15-Months	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
15 Month Home Visit	The Week Before the Lab	15 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
15 Month Child C. Visit	The Week Before 15-Months	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
24 Month Lab Visit	24-Months 7 days	24 Months, 0 Days to less than 26 Months, 0 Days	26 Months, 0 Days to less than 29 Months, 0 Days
24 Month Home Visit	24-Months 0 days	24 Months, 0 Days to less than 26 Months, 0 Days	26 Months, 0 Days to less than 29 Months, 0 Days
24 Month Child C. Visit	24-Months 7 days	24 Months, 0 Days to less than 26 Months, 0 Days	26 Months, 0 Days to less than 29 Months, 0 Days

Rules of thumb for scheduling the visits:

1. The home visit should precede the lab visit, unless this is logistically impossible (e.g., cancellations). This is very important and you should change this order only if you risk losing a visit.
2. Because of difficulties scoring strange situations on older toddlers, the 15-month lab visit should be conducted as close to 15 months as possible.
3. The child must be awake, alert, and healthy for the lab visit. There should also not be any unusual separations from the mother in the previous week. The child should NOT have changed child care in the two weeks prior to the lab visit. Moreover,

avoid scheduling the lab visit after the mother has picked the child up from child care, after a lengthy shopping trip, or any other stressful event. The mother and child should be together for at least two hours prior to the lab visits. This is particularly crucial for the 15-month lab assessment of attachment.

4. At 15 months, the child must be awake and alert for at least part of the home visit. At 24 months, the home visit will involve a 2 hour observation to complete the Attachment Q-Set. In general, allowing time for greeting the mother, taping or observing the mother, questioning the mother, distributing the MacArthur Language Inventory, and giving the mother information for the lab visit, the visitor will be in the home for 2 1/2 - 3 hours. That amount of time should be scheduled with the mother.

The scheduling of the 24 month home visit must be done very carefully with several concerns in mind:

First, the mother must know that we have to have a time when the child will be awake and rested (and healthy) for the full two hours. If the child is asleep when we arrive or goes to sleep, it will either lengthen this visit or result in the need for a second visit.

Second, we prefer a time when mother and child (and younger sibling) only are in the home. It is much harder to do the visit if the father and older siblings are present, and we MUST avoid observing most nonemployed mothers with only mother and child

present while observing most employed mothers with whole families present. Therefore, we need to make extra effort to schedule when just mother and child and younger siblings, if any, are home. However, we don't wish to ask the impossible of families. Find out if there is a normally occurring time when just mother and child (and younger sibling) are home when we can come and then schedule for that time. If those times prove impossible, find out if there is a time when it would be convenient for just mother and child to be in the home. If there simply is not, then schedule for a time when father and/or older siblings are home. The observation CANNOT be done if other children who don't live in the home are there. Make sure that the mother knows that she should be in the home for the full two hours of observation, while the father and older siblings can come and go if they wish.

After the phone call, a confirmation letter should be sent (see Appendixes A and B). This letter should include the dates and times of the visits.

Please use the following descriptions of the home and lab visits when scheduling these visits. They are slightly revised from what is on the scantron forms.

SCRIPTS

"Now, the last thing I need to do is schedule our visit to your home and your visit to our playroom when CHILD is ____ (15,24) months old. You may remember that at ____ (15,24) months we will need to see you in your home and also at our children's playroom at [SITE LOCATION]. I would like to ask you a few questions and tell you a little bit about these visits. (Ask 3 questions on page 1 and code answers.)

AT 15 MONTHS:

The home visit will take about 2 hours and will be similar to the Six Month Visit. We will ask you a few questions, like we did before and ask you to fill out some of the same questionnaires. We will also videotape you and CHILD together for about 15 minutes. CHILD will obviously need to be awake for this part of our visit. We will also leave a questionnaire with you to complete and then bring along when you come to visit our playroom.

AT 24 MONTHS:

The home visit will take about 2 1/2 hours. In general we will spend our time observing you and CHILD as you go about your normal activities around the house. We want you to do what you typically would be doing at this time of day. We need to make sure that we can come when CHILD will be rested and awake for the visit. This visit should be scheduled so that there are no overnight separations from the CHILD in the week prior to the visit or any other big changes in routine. We'd prefer to see you on a day when you and your child have been together all day. If this is not possible, we'd just like to make sure that we avoid times, such as immediately following a pick-up from child care or after a lengthy shopping trip, when your child might be very tired. Also, we prefer a time when just you and CHILD (and younger sibling) are at home alone. Because it is very important to do the visit the same way for each family, we ask that fathers and older siblings are not present during this visit. Some families may not have older children and in many cases fathers are unable to be present. (We will pay for your older child/children to go to a sitter if this will help).

I know you're very busy, especially with a toddler. We'd like to pick a time for this visit that is best for you and for CHILD. Again, we will be observing you and CHILD as you go about your normal routine. This might include household chores or meal preparation or playtime, etc. When would be a good time for us to come?

ADD IF MOTHER IS EMPLOYED: Would it be helpful if we came on _____ (suggest time outside of working hours).

ARRANGE A TIME FOR THE HOME VISIT. (should be scheduled before the lab visit) **WRITE DATE AND TIME ON THE INFORMATION SHEET FOR THE OBSERVER.**

Who else will be at your house during that time? (Recall that we want only mother and child, younger sibs ok) (WRITE DOWN ON INFORMATION SHEET).

Please remember that you don't need to prepare anything, and don't worry about cleaning up. We know you are very busy. We want this to be as informal as possible, and we'll be informal too. Please don't go to any trouble.

CONFIRM APPOINTMENT TIME. ADDRESS AND PARKING SPOT.

Now we would like to set up the visit to our playroom.

AT 15 MONTHS:

The playroom visit will take about 1 1/2 hours. During that time, we will observe and videotape CHILD as he/she plays with toys that we provide and during two brief separations from you. You will be able to see your child at all times, and you may return to your child whenever you like.

We will also administer a measure of developmental progress. At the end of the visit we will weigh and measure the length of CHILD and write down the weight and height for you. You may want to dress your child so that he/she can be weighed in tee shirt and diaper (or underpants). If CHILD wears heavier clothing, his/her weight will not be accurate.

AT 24 MONTHS:

The playroom visit will take about 1 1/2 hours. During this time we will watch your child play with different toys. Similar to what we did at 15 months, we will have 3 toys for you to give the child. We will also administer a measure of developmental progress. We will have time for a brief snack and then we will have about a 20 minute interview with you and ask you to complete just 2 questionnaires."

Part 7: ASSEMBLE QUESTIONNAIRE PACKET

The 23 month phone caller will assemble the Questionnaire Packet for the home visitor. The Home visitor is to be kept blinded about the current work and child care situations. After scheduling visits or at the end for the interview if another caller schedules the visit, the 23 month phone caller will need to determine if during the course of the interview it is known that the mother works for pay 10 or more hours per week. If the

phone caller does not know definitely that the mother is or is not working for pay 10 or more hours per week the caller will say, "I will be putting together the packet of questionnaires which will be left with you at the home visit. To do this, I need to get some information about employment. Are you now working for pay 10 or more hours per week?" Record answer on the information sheet.

The following questionnaires should be placed in a large envelope (9 X 12) labeled with the family name and given to the home visitor who will be conducting the home visit.

- The MacArthur Communicative Inventory: Toddlers
- My Feelings (Form 15D)
- Parental Care (Form 15E)
- Relationships With Other People (Form 15F)
- Family Finances (Form 15H)
- Parent Experiences (Form 15I)

For mothers employed for pay 10 or more hours per week:

- Job Experiences (Job Stress) (Form 15J)

For mothers with observable child care:

- My Child Care (Form 15K)

XVII. DEBRIEFING

Follow the script as written, being sure to give the mother a chance to ask any questions she may have. It is a good idea to

make a note of any questions and what your response is, and to check with your site coordinator and/or P.I. to be sure all staff members are following the same procedures. If you are at all unsure about the answer to a question, do not try to answer it. Instead, tell the mother you will find out and call her back. Talk to the site coordinator and/or P.I. and arrange for someone to call the mother back within that same day if possible.

Conclude the interview by telling the mother when she will be contacted next and what will happen at that contact.

XVIII. APPENDICES

A. 15-month Materials

A1. Sample Letter to Send to Mother When Unable to Contact by Phone

Mother's Name
Last Known Address

Dear _____:

Thank you for agreeing to participate in the NICHD Study of Early Child Care. We have enjoyed getting to know you and BABY, and it's good to have you as part of the study.

We have been trying to contact you to find out how you and BABY are getting along. Please fill out and return the enclosed card to us, or call our offices at AREA CODE/PHONE. Feel free to call us collect. Also, you can call at any time and leave a message on our answering machine. Please let us know the best way to contact you.

We hope things are going well for you and BABY. We look forward to hearing from you soon.

Sincerely,

Project Staff Member

Enclosure: Return postcard

**A2. Materials to Send to Mothers Who Let You Contact the
Provider**

LETTER DESCRIBING 15-MONTH CHILD CARE VISIT FOR MOTHER

**Mother's Name
Last known address**

Dear :

As we discussed on the phone, we will be contacting (NAME OF CARE PROVIDER) about our visit to observe CHILD [or when CHILD is at the day care center].

We want to find out what CHILD is usually like when (she/he) is in (his/her) care [or at the center], and also a little about the people caring for (him/her). To do this, someone from our staff will visit BABY's child care to watch for about three hours on two different occasions. This person will also talk to the care provider about (his/her) education and experiences in caring for children and about how your child spends the day. The care provider will also be asked to complete several brief questionnaires about your child, similar to those you have completed, and about (his/her) feelings about providing child care.

(His/Her/Their) participation in the study will be of great value. It will provide important information to help us learn more about those things that lead to healthy development for young children.

Thank you for your help.

Sincerely,

Project Staff Member

**A3. Materials to Send to Mothers Who Want to Make First Contact
With Child Care Provider**

1. Letter describing 15-month child care visit for
mother

Mother's Name
Last known address

Dear :

As we discussed on the phone, we would like you to talk to
(NAME OF CARE PROVIDER) about our visiting when (she/he) is
caring for CHILD [or when CHILD is at the day care center]. We
have enclosed a list of points that you should be sure to mention
when you talk to your provider.

We want to find out what CHILD is usually like when (she/he)
is in (his/her) care [or at the center], and also a little about
the people caring for (him/her). This would mean someone from
our staff coming to watch for about three hours on two different
occasions. This person would also talk to the care provider
about (his/her) education and experiences in caring for children
and about how your child spends the day. The care provider would
also complete several brief questionnaires about your child,
similar to those you have completed, and about (his/her) feelings
about providing child care.

The care provider may be a little uncertain about the visits
and want to know more about them. We have enclosed some
information that you can give (him/her). Specifically, feel free
to mail or give the enclosed letter from us, along with the study
description, to your care provider. You can also tell (him/her)
that we will be phoning to talk about the visits in more detail
and to answer any questions.

(His/Her/Their) participation in the study will be of great
value. It will provide important information to help us learn
more about those things that lead to healthy development for
young children.

Thank you for your help.

Sincerely,

Project Staff Member

Enc: Letter to Care Provider
Study Description for Care Provider
List of points to mention to the provider

BE SURE TO MENTION TO YOUR PROVIDER that...

1. You have given your permission for your child to be visited at child care.
2. You have been in the study since your child's birth and (we sincerely hope) have enjoyed the experience.
3. All information that is gathered on the child and the child's child care is kept strictly confidential. This information we gather during our visits will only be shared with project staff. No one will be named in any reports of the study. All information is kept in locked files at the site.
4. We need the provider's permission, in addition to yours, to visit the child at child care.
5. We are not going to evaluate the child care provider or setting. We just need to learn about where and how the child spends his/her days.
6. Someone from the study at the site will be calling them in the next few days to describe the child care visit in detail and to answer any questions.
7. We will pay the provider \$40 for his/her participation.
8. You hope she/he/they will participate.

A4. Letter for mother to send to her provider

Dear _____ (NAME OF PROVIDER) _____,

As you may already know, _____ (MOTHER) _____, and her child, _____ (CHILD) _____ are taking part in an exciting and important study called the NICHD Study of Early Child Care. They have been in the study since the CHILD was born.

The major aim of the study is to learn how the different people, places, and events in the lives of young children affect their development. We have attached a one-page description of the study for you to read and even to post if you would like.

As part of the study, we need to see _____ (CHILD) _____ in his/her child care setting since this is such an important part of his/her early life. We would like to come and _____ (CHILD) _____, when she/he is with you. _____ (MOTHER) _____ has given us their permission to do this. We will pay you \$40 for your participation.

We know you are busy, and we will arrange our visits at times convenient to you. We will also respect the routines and responsibilities of the caregiver(s) during our visits. We want to see what the child is usually like when she/he is with you. We would just watch whatever the child typically does and ask some questions about how she/he usually spends the day. We would also ask you some questions about your own education, child care experiences, and feelings about providing child care.

Your participation in the study will provide valuable information which will help all of us learn more about young children's development. All of this information will be kept strictly confidential. We will be calling you to tell you more and to answer any questions that you may have about the study.

Sincerely,

Project Coordinator

Enc: Study Description

A5. Description of study

THE NATIONAL INSTITUTE OF CHILD HEALTH AND DEVELOPMENT

STUDY OF EARLY CHILD CARE

Children born today will be growing up in a world different from that of their parents. How will growing up in the 1990's affect children's development? To answer this most important question for America's future, the National Institute of Child Health and Human Development has funded the NICHD Study of Early Child Care.

The NICHD Study of Early Child Care is being conducted at ten different sites in the United States. The main aim of the study is to learn about the variety of people, places, and events that children experience in their early years and the many pathways that lead to healthy development. Aspects of development that will be studied include social, language, cognitive, and health outcomes.

Families become involved in the study on a voluntary basis soon after the infant's birth. Several times during the three years that the families are involved in the study, the children, their parents, and other caregivers will be observed and interviewed. Parents are asked to describe their views about childrearing, their feelings about working and parenting, and their perceptions of the child's personality and behavior. Because child care outside the family is also an extremely important setting in which children grow and change, caregivers are asked to participate as well. Summary results will be available to all study participants at the conclusion of the project in 1995.

VISITS TO CHILD CARE SETTINGS

Each child in the study is visited in his or her care setting on two different days, when he or she is 6, 15, 24, and 36 months of age.

At the first visit, a staff member observes the child for about 3-4 hours. She tries not to interfere with the usual routine in the child's room. At the end of the visit, she leaves 4 questionnaires for the child's caregiver(s) to fill out before the second visit. These questionnaires contain questions about the caregiver's education and experience. This should take no more than 20 minutes of the caregiver's time, and the staff members work around the schedule and routines of the caregiver(s).

At the second visit, the staff member again observes the child for about 3-4 hours. Then, she talks to the caregiver(s) briefly about the child's activities and about the caregiver's education and experience. Again this should takes no more than 20 minutes of the caregiver's time, and the staff member will be considerate of the caregiver routines and responsibilities.

Because we want to see what usually happens when children are in child care, we try to make our visit interfere as little as possible with the caregiver's routine.

The results of this study will not only guide policy makers, but will also be of more immediate use to parents and child care providers as they engage in the rewarding, but challenging, responsibility of rearing young children.

A6. Sample Appointment Letter for 15-Month Home Visits

Date

Name

Last known address

Dear :

This letter is to confirm the appointment that we made. I will be visiting with you at your home on (day of week, month, date, time).

We would like you to bring CHILD to our playroom at the University on (day of week, month, date, time). We will give you directions to the playroom and a parking permit before your visit.

Please remember to bring along the completed Version of the MacArthur Communicative Development Inventory, which we gave to you during the home visit. If you have any questions or problems with the form, we will be able to go over them at the time of the lab visit. Thank you for taking the time to give us this valuable information!

Please feel free to contact me at (608) 263-1565 or 263-1662 if you have any questions or concerns. I look forward to visiting with you.

Sincerely,

NAME

NICHD Study of Early Child Care

B. 24-month Materials

B1. Sample Letter to Send to Mother When Unable to Contact by Phone

Mother's Name
Last Known Address

Dear _____:

Thank you for agreeing to participate in the NICHD Study of Early Child Care. We have enjoyed getting to know you and BABY, and it's good to have you as part of the study.

We have been trying to contact you to find out how you and BABY are getting along. Please fill out and return the enclosed card to us, or call our offices at AREA CODE/PHONE. Feel free to call us collect. Also, you can call at any time and leave a message on our answering machine. Please let us know the best way to contact you.

We hope things are going well for you and BABY. We look forward to hearing from you soon.

Sincerely,

Project Staff Member

Enclosure: Return postcard

82. Materials to Send to Mothers Who Let You Contact the
Provider

LETTER DESCRIBING 24-MONTH CHILD CARE VISIT FOR MOTHER

Mother's Name
Last known address

Dear :

As we discussed on the phone, we will be contacting (NAME OF CARE PROVIDER) about our visit to observe CHILD [or when CHILD is at the day care center].

We want to find out what CHILD is usually like when (she/he) is in (his/her) care [or at the center], and also a little about the people caring for (him/her). To do this, someone from our staff will visit BABY's child care to watch for about three hours on two different occasions. This person will also talk to the care provider about (his/her) education and experiences in caring for children and about how your child spends the day. The care provider will also be asked to complete several brief questionnaires about your child, similar to those you have completed, and about (his/her) feelings about providing child care.

(His/Her/Their) participation in the study will be of great value. It will provide important information to help us learn more about those things that lead to healthy development for young children.

Thank you for your help.

Sincerely,

Project Staff Member

**B3. Materials to Send to Mothers Who Want to Make First Contact
With Child Care Provider**

1. Letter describing 24-month child care visit for mother

Mother's Name
Last known address

Dear :

As we discussed on the phone, we would like you to talk to (NAME OF CARE PROVIDER) about our visiting when (she/he) is caring for CHILD [or when CHILD is at the day care center]. We have enclosed a list of points that you should be sure to mention when you talk to your provider.

We want to find out what CHILD is usually like when (she/he) is in (his/her) care [or at the center], and also a little about the people caring for (him/her). This would mean someone from our staff coming to watch for about three hours on two different occasions. This person would also talk to the care provider about (his/her) education and experiences in caring for children and about how your child spends the day. The care provider would also complete several brief questionnaires about your child, similar to those you have completed, and about (his/her) feelings about providing child care.

The care provider may be a little uncertain about the visits and want to know more about them. We have enclosed some information that you can give (him/her). Specifically, feel free to mail or give the enclosed letter from us, along with the study description, to your care provider. You can also tell (him/her) that we will be phoning to talk about the visits in more detail and to answer any questions.

(His/Her/Their) participation in the study will be of great value. It will provide important information to help us learn more about those things that lead to healthy development for young children.

Thank you for your help.

Sincerely,

Project Staff Member

Enc: Letter to Care Provider
Study Description for Care Provider
List of points to mention to the provider

BE SURE TO MENTION TO YOUR PROVIDER that...

1. You have given your permission for your child to be visited at child care.
2. You have been in the study since your child's birth and (we sincerely hope) have enjoyed the experience.
3. All information that is gathered on the child and the child's child care is kept strictly confidential. This information we gather during our visits will only be shared with project staff. No one will be named in any reports of the study. All information is kept in locked files at the site.
4. We need the provider's permission, in addition to yours, to visit the child at child care.
5. We are not going to evaluate the child care provider or setting. We just need to learn about where and how the child spends his/her days.
6. Someone from the study at the site will be calling them in the next few days to describe the child care visit in detail and to answer any questions.
7. We will pay the provider \$40 for his/her participation.
8. You hope she/he/they will participate.

B4. Letter for mother to send to her provider

Dear _____ (NAME OF PROVIDER) _____,

As you may already know, _____ (MOTHER) _____, and her child, _____ (CHILD) _____ are taking part in an exciting and important study called the NICHD Study of Early Child Care. They have been in the study since the CHILD was born.

The major aim of the study is to learn how the different people, places, and events in the lives of young children affect their development. We have attached a one-page description of the study for you to read and even to post if you would like.

As part of the study, we need to see _____ (CHILD) _____ in his/her child care setting since this is such an important part of his/her early life. We would like to come and _____ (CHILD) _____, when she/he is with you. _____ (MOTHER) _____ has given us their permission to do this. We will pay you \$40 for your participation.

We know you are busy, and we will arrange our visits at times convenient to you. We will also respect the routines and responsibilities of the caregiver(s) during our visits. We want to see what the child is usually like when she/he is with you. We would just watch whatever the child typically does and ask some questions about how she/he usually spends the day. We would also ask you some questions about your own education, child care experiences, and feelings about providing child care.

Your participation in the study will provide valuable information which will help all of us learn more about young children's development. All of this information will be kept strictly confidential. We will be calling you to tell you more and to answer any questions that you may have about the study.

Sincerely,

Project Coordinator

Enc: Study Description

B5. Description of study

THE NATIONAL INSTITUTE OF CHILD HEALTH AND DEVELOPMENT

STUDY OF EARLY CHILD CARE

Children born today will be growing up in a world different from that of their parents. How will growing up in the 1990's affect children's development? To answer this most important question for America's future, the National Institute of Child Health and Human Development has funded the NICHD Study of Early Child Care.

The NICHD Study of Early Child Care is being conducted at ten different sites in the United States. The main aim of the study is to learn about the variety of people, places, and events that children experience in their early years and the many pathways that lead to healthy development. Aspects of development that will be studied include social, language, cognitive, and health outcomes.

Families become involved in the study on a voluntary basis soon after the infant's birth. Several times during the three years that the families are involved in the study, the children, their parents, and other caregivers will be observed and interviewed. Parents are asked to describe their views about childrearing, their feelings about working and parenting, and their perceptions of the child's personality and behavior. Because child care outside the family is also an extremely important setting in which children grow and change, caregivers are asked to participate as well. Summary results will be available to all study participants at the conclusion of the project in 1995.

VISITS TO CHILD CARE SETTINGS

Each child in the study is visited in his or her care setting on two different days, when he or she is 6, 15, 24, and 36 months of age.

At the first visit, a staff member observes the child for about 3-4 hours. She tries not to interfere with the usual routine in the child's room. At the end of the visit, she leaves 4 questionnaires for the child's caregiver(s) to fill out before the second visit. These questionnaires contain questions about the caregiver's education and experience. This should take no more than 20 minutes of the caregiver's time, and the staff members work around the schedule and routines of the caregiver(s).

At the second visit, the staff member again observes the child for about 3-4 hours. Then, she talks to the caregiver(s) briefly about the child's activities and about the caregiver's education and experience. Again this should take no more than 20 minutes of the caregiver's time, and the staff member will be considerate of the caregiver routines and responsibilities.

Because we want to see what usually happens when children are in child care, we try to make our visit interfere as little as possible with the caregiver's routine.

The results of this study will not only guide policy makers, but will also be of more immediate use to parents and child care providers as they engage in the rewarding, but challenging, responsibility of rearing young children.

B6. Sample Appointment Letter for 24-Month Visits

Date

Name

Last known address

Dear :

This letter is to confirm the appointment that we made. I will be visiting with you at your home on (day of week, month, date, time).

We would like you to bring CHILD to our playroom at the University on (day of week, month, date, time). We will give you directions to the playroom and a parking permit before your visit.

Please remember to bring along the completed packet of questionnaires which we gave to you during the home visit. If you have any questions or problems with the form, we will be able to go over them at the time of the lab visit. Thank you for taking the time to give us this valuable information!

Please feel free to contact me at (608) 263-1565 or 263-1662 if you have any questions or concerns. I look forward to visiting with you.

Sincerely,

NAME

NICHD Study of Early Child Care

CHAPTER 14
OVERVIEW OF THE 15-MONTH VISITS:
HOME, LAB, & CHILD CARE VISITS
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CHAPTER 14

OVERVIEW OF THE 15-MONTH VISITS:

HOME, LAB, AND CHILD CARE VISITS

I. OVERVIEW OF THE HOME, LAB, AND CHILD CARE VISITS

When the child is 15 months, data are collected in three types of visits. The following is a list of the visits and the measures collected:

A. Home Visit

1. Warm up and HOME Inventory
2. Mother-child interaction ("3 bags")
3. Interview to update information
4. Questionnaires (NOT MAILED AHEAD)
 - My Feelings (depression)
 - Parental Care (separation distress)
 - Relationships with Other People (social support)
 - Family Finances (finances)
 - Parenting Experiences (parent stress)
 - Work and Family (EMPLOYED MOTHERS ONLY)
 - Job Experiences (job stress)
 - My Child Care
 - Language Questionnaire (MacArthur)
5. Debriefing and instructions for coming to the Lab

B. Lab Visit

1. Introductions, instructions, and Solitary Play
2. Strange Situation
3. Snack
4. Bayley MDI
5. Growth Measures

C. Child Care Visits

1. ORCE (Behavioral and Qualitative Ratings)
(4 cycles)
2. Profile
3. HOME Inventory (Family Day Care and Nanny Care ONLY)
4. Caregiver Interview
5. Caregiver Questionnaires

II. SCHEDULING THE VISITS

The observation windows for the 15 month visit are as follows:

<u>Visit</u>	<u>Ideal Time</u>	<u>Regular Window</u>	<u>Exception Period</u>
15 Month Lab Visit	The Week Before 15-Months	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
15 Month Home Visit	The Week Before the Lab	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
15 Month Child C. Visit	The Week Before 15-Months	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days

A. Phone calls to schedule the visits (home, lab, and child care) can begin at 12 1/2 months.

B. Visits should ideally take place during the 2 weeks before the child's 15-month birthday. It is important to measure attachment during the lab visit as close to 15 months as possible.

C. Visits should not be initially scheduled for the month after the child's 15 month birthday. This month should be used for make-up visits.

D. If possible, schedule the home visit before the lab visit. However, be flexible and switch the order if you may lose data otherwise.

E. If the child's alternate care arrangement is in his/her own home, the home visit to the mother should be done before the visit to the child care provider.

F. If child care does not take place in the child's home, then the order of the child care and home visits is flexible.

G. The first child care visit should be within 1 month of the home visit.

III. DATA COLLECTED DURING THE EXCEPTION PERIOD

All data collected during the exception period must have the written approval of a principal investigator. Fill out the EXCEPTION PERIOD DATA COLLECTION APPROVAL Form DM-G, and have the principal investigator sign it. (See Appendix of Chapter 14).

The form should be sent along with the data that were collected during the exception period, with the form at the top of the pile of data and underneath the transmittal form. Also indicate on the transmittal form that the form is being included in the shipment .

IV. RULES FOR OVERLAP OF STAFF BETWEEN VISITS

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A. At 15-months, the same person cannot not do the home and child care visits for the same family.

B. The child care and home visitors for a particular family may conduct the lab visit; however, staff with whom the child is familiar, (for example, the home visitor or the child care visitor at 15 months), must not be the "stranger" during the Strange Situation procedure.

Appendix A. DM-G Form

**EXCEPTION PERIOD DATA COLLECTION APPROVAL -
DATA COLLECTION BEYOND ASSESSMENT WINDOW**

CHILD IDENTIFICATION NUMBER _____

This subject will have data collected
beyond the date of the regular assessment window.

DATA TO BE COLLECTED (List form numbers) _____

REASON DATA NOT ABLE TO BE COLLECTED DURING SCHEDULED WINDOW:

Circle all that apply -

1. FAMILY NOT ABLE TO SCHEDULE APPOINTMENT DURING REGULAR ASSESSMENT WINDOW
2. NOT ABLE TO LOCATE FAMILY TO MAKE APPOINTMENT DURING REGULAR ASSESSMENT WINDOW
3. CENTER/CAREGIVER NOT ABLE TO SCHEDULE APPOINTMENT UNTIL AFTER REGULAR ASSESSMENT WINDOW
4. NOT ABLE TO LOCATE CENTER/CAREGIVER TO MAKE APPOINTMENT DURING REGULAR ASSESSMENT WINDOW
5. STAFF AT SITE NOT ABLE TO SCHEDULE DATA COLLECTION DURING REGULAR ASSESSMENT WINDOW
7. CHANGE IN CHILD CARE ARRANGEMENT REQUIRING A TWO-WEEK ADJUSTMENT PERIOD
6. OTHER _____

SIGNATURE OF PI APPROVING DATA COLLECTION BEYOND ASSESSMENT WINDOW

DATE APPROVED _____

Comments: _____

Chapter 15

Section 1

OPERATIONS MANUAL FIFTEEN MONTH HOME VISIT

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ACKNOWLEDGEMENTS

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Responsibility for creating the HOME Submanual (Section 2) was taken by Bob Bradley, working from the Six Month Submanual for the HOME created by Margaret Tresch Owen working from material supplied by Bettye Caldwell. The Mother-Child Interaction Submanual (Section 3) was created by Margaret Tresch

Owen. Jay Belsky and Celia Brounell had significant roles in the preparation of this manual. Responsibility for the Interview and Questionnaires Submanual (Section 4) was taken by Marsha Weinraub and her committee of Martha Cox, Aletha Huston, Nancy Marshall, and Marion O'Brien. The Interview was developed by Nancy Marshall, based on the One and Six Month Interviews developed by Marion O'Brien. Responsibility for developing the procedures and forms for collecting ear and upper respiratory infection information was taken by Kathryn Hirsh-Pasek and Dede Kaufman. Responsibility for producing the Operations Manual and coordinating the submanuals was taken by Marsha Weinraub, Margaret Tresch Owen and Deborah Vandell, chair of the 15-month subcommittee.

Chapter 15

Section 1

OPERATIONS MANUAL FIFTEEN MONTH HOME VISIT

I. OVERVIEW OF THIS MANUAL

This manual provides specific information necessary for conducting the 15-month home visit. It is organized in such a way as to give general information about the visit in the first two sections, more specific information about setting up and managing the course of the visit in the third and fourth sections, instructions for activities to be completed after the visit to the home in the fifth section, instructions for unusual circumstances in the sixth section, safety guidelines for making home visits in the seventh section, and general information on training for the visit in the eighth section. The specific instructions for conducting the MacArthur Inventory, the HOME, the 15-month interview and questionnaires, and the mother-child videotape are contained in Sections 2 (HOME Inventory), 3 (Videotaping Mother-Child Interaction), and 4 (Interview and Questionnaires) of this Chapter. Information about how to administer and collect the ear infection (otitis media) information had been placed in Section 4 (IV. G. 2.) of this chapter.

II. GENERAL CONSIDERATIONS FOR THE FIFTEEN MONTH HOME VISIT

A. Your Role as a Visitor

As a home visitor, your main objective is to obtain accurate, reliable information in the most pleasant way possible. Home visitors must balance their professional role and objectives with their role of being a friendly, respectful guest in someone's home. Many unexpected things arise in the home that require flexibility on the part of the visitor. Your flexibility conveys your respect for the person and the way she does things in her home. Your flexibility and openness, however, should in no way compromise your professional agenda. The tone of the home visit is that of a friendly, relaxed yet professional visit.

There are several ways that you can prepare yourself for this role. First, become totally familiar with the protocol. This familiarity will make you comfortable enough to be flexible and also will help keep your professional agenda in mind as you accommodate to the unique circumstances facing you. Second, become familiar with fifteen-month-olds and the kinds of issues mothers are concerned with at this time. Third, you can dress the part: wear casual, yet professional clothes. Fourth, continually examine for yourself any situations that arise which prevent you from feeling totally comfortable with your role. Discuss these with your PI or site coordinator and see if there is a better way to deal with such situations in the future.

B. About Fifteen-month-olds

It is important for the Visitors to be comfortable with 15 month-olds and knowledgeable about their ways. Fifteen-month-olds are on the borderline between Infancy and Toddlerhood. Throughout this manual, we will try to refer to them as either child or toddler, as these are the terms most 15-month-olds would prefer if they were asked. Fifteen-month-olds sometimes don't take kindly to being called "babies". Reading about fifteen-month-olds is a good idea. Site Directors often can recommend good reading material; there are several developmental textbooks that do an excellent job. Here we present a few crucial points, especially for those Visitors less familiar with children of this age.

First, as soon as you see the child, notice and comment on something positive about this child to the mother. Not saying anything is sometimes taken as a slight; saying something honestly nice is easy to do about even the most difficult of children. Be careful not to overdo it or to say anything judgmental that could be taken as negative -- even an innocent comment can stay on the mother's mind for a long time.

Do not speak to the child immediately. Wait for the child to warm up to you. When you feel this happening, you may want to greet the child in a gentle and kindly way. Usually it is helpful to speak to the child at the child's eye level. For this you may need to get down on the floor. Be sure that before you leave the home, you have at least attempted a short conversation

or game (even a sophisticated version of peek-a-boo) with the child, so the family knows you care about the child as well as the mother. Visitors may find it helpful to find 15-month-olds that they can spend time around in order to become more familiar with children this age.

If you feel that you may be contagious with any illness, be sure to reschedule or find a substitute. Even if you think that you are not contagious, mothers will not appreciate your coughing and sneezing around her home.

C. When the Mother Reveals Personal Problems

Occasionally, in a mother's eagerness to talk, she makes an implied or direct appeal for help with her own personal problems. The Visitor should be careful about feeling that she must handle these problems or solve them for the mother. The Visitor might say something like "I can understand your being upset (or concerned) about that. When we finish with the things we have to do, maybe we can talk about it more."

Each site has developed its own resource list to meet the needs of their families on a case-by-case basis. We will not routinely give mothers any information concerning resources. This may constitute an intervention. For example, if the list contained information about "Fun Things to Do With Your Kids," we may be subtly encouraging mothers to behave in certain ways with their children. If the mother requests this information, however, we do have a responsibility to be reasonably trained to

provide information about available resources.

Researchers at each site should be relatively familiar with the services that are available to parents in their area. If a situation arises in which a mother requests information or some type of referral, the researcher may say something like, "I can see that you would like help. I am not (trained) (in a position) to help you, but perhaps you would like me to talk with Dr.---, our Director, and he/she will know of someone that could be of help to you." Immediately after the visit is completed, document the mother's concerns and requests on the Interviewer Report Form (see Interview and Questionnaires Sub-Manual) and discuss the situation with your Study Coordinator and/or Principal Investigator. Get back to the mother as promptly as possible with the appropriate information. If it seems appropriate to have your PI or SC speak with the mother, the Visitor should ask if the mother would like the Director to call.

Each site should keep a record of the kind of information distributed to a particular parent and what impact, if any, this had on the family's life, if known. (This can also be recorded on the Interviewer Report Form.)

D. When the Visitor Observes Family Difficulties

A more serious and difficult problem arises when something is revealed at the home visit that suggests that the child (or mother) is in "jeopardy". (See Principle 9 of the SRCD Ethical Standards for Research with Children.) For example, you may

suspect some form of child abuse. Prior to conducting any home visits, the Visitor should become familiar with indicators of child abuse and the laws governing reporting this to the authorities in your state. You should immediately report to your PI any instance of abuse or suspicions of abuse. A list of indicators and definitions of child abuse, prepared by the Wisconsin site, is included in Appendix A of Chapter 6.

E. The Key to a Successful Visit

As much as possible, the 15-Month Home Visit should be pleasant and satisfying for the families. In this regard, it is helpful for you to see this as a friendly visit. The Visitor must be as relaxed as possible and try to help the mother feel relaxed as well. On first entering the home, spend a few minutes just chatting. "How have you been?" may be reasonable to ask, or you may discuss any other topic of common interest (the weather). Making positive comments about the house, children, pets are all things that make people feel more relaxed and positive toward you. In other words, be a polite, friendly visitor to the home, showing you are interested in the family as people as well as in the information that they can provide.

Show interest and positive attention to the mother. Look at the mother as she answers your questions. Don't just look down for where to record the answer. Be careful, however, to avoid using terms such as "That's fine", "Good", or "Okay" after the mother completes an answer. Even seemingly innocuous statements

after the mother says something may subtly reinforce particular types of answers.

In either the HOME or the Interview, if the mother elaborates on something when you really only need a brief answer, say something polite like, "Yes, I see what you mean, I think I've got what I need here." If she goes on and on and it's becoming a problem, say "You're giving me a lot of information, but I'm afraid I'll take up too much of your time, so I'll try to let you know when I've got enough so we can move on." Then, let her know that you have enough information and that you need to go to the next question. Remember that you don't want people to feel cut off, but that people may become irritated if your visit lasts longer than you promised (even if the cause is due to the mother's desire to give you more than you've requested of her). In striving to keep the visit pleasant and friendly you must strive not to let it become tedious in terms of allowing it to take longer than you promised. This must be handled delicately. While we do not wish to dwell on problems or concerns or get distracted by digressions, interviews should be handled with sensitivity. Sensing indifference could lead the mother to treat our needs for information with suspicion or indifference in turn.

F. Sharing Personal Information

You must avoid sharing personal information. By sharing such information, you may inadvertently establish certain response biases in the mother as she assesses what your values

may be. The reliability and validity of the data depend upon the Visitor being able to establish an interpersonally neutral atmosphere. Making evaluative statements after the mother answers a particular question, making evaluative comments on behaviors observed in either mother or toddler or sharing personal information with her are major ways that a Visitor can introduce bias into the data collected. The visitor is better advised to ask the mother what she thinks than to express the visitor's own opinion.

G. Expressing Appreciation

Be sure to emphasize at some point during the visit the importance of the mother's contribution to the research, how worthwhile and important the research is, and how much the mother's time is appreciated. This is often a good thing to do as you are leaving, if it hasn't come up before. Say something like, "We really appreciate your time. This research is important to understanding how early experiences affect how children develop, so we appreciate that you are willing to help us with this."

III. THE VISITOR(S)

A. Task Distribution

Two visitors will collect data for the visit. The second visitor will help in the set-up of the equipment for the

videotaping while the first visitor administers the HOME. After the videotaping, the second visitor can break down the equipment while the first visitor administers the standardized interview and questionnaires. During the administration of the Interview and Questionnaires, it may be especially helpful for the second visitor to engage the 15-month-old in activities so as to enable the mother to give full attention to the interview and questionnaires.

As you may know, at the six month home visit, only one visitor collected data in the home. However, because of the greater mobility of the 15-month-old and the greater likelihood that the mother is employed at 15 months (and so will need more time on the interview and questionnaires and may have a shorter time "window" available for scheduling this visit), two visitors have been assigned. The task distribution will be as follows:

	Visitor #1	Visitor #2
1. HOME	Interview mother	Friendly nonparticipant set up video equipment
2. Videotaped Interaction	Operate camera	Occupy others or "disappear"
3. Interview & Questionnaires	Interview mother	Occupy child and others

The visitors should designate one person to be the Primary Visitor. This is the person who will be responsible for talking with the mother, making sure the visit flows smoothly, for reviewing forms, and for completing the post-visit information. The second home visitor may be a research assistant or

childminder. This person must be familiar with the home visit protocol, sensitive to the needs of children and family members, qualified to set up or assist in the set up of equipment, and able to handle phone calls and deliveries and other interruptions that may occur during the videotaping. This person must be able to intervene as necessary in family activities so as to be of assistance to the interviewer in following the common protocol. Home visitors have reported that adequate training of this individual is required.

B. Who Can be Home Visitors

The interviewer for any given family should be different from the research assistant who observes the same family's child in child care at 15-months. Home visitors may or may not have conducted the 1 or 6 month home visit. If, for some reason, the 15-month home visit cannot be completed in one visit, at least one of the same visitors should conduct the follow-up visit.

In unusual circumstances, it is possible to have only one home visitor. One visitor may be sent to the home under any of the following conditions:

1. The mother has specifically requested, without prompting, that only one person come to the home, either on the scheduling call, the confirming call or on a previous visit.
2. The home is so small (e.g. trailer home, small apartment or house) that a second visitor would be unable to distract the other family members during the videotaping and interview segments of the visit.

3. Only the target child will be present in the home, and it can be reasonably predicted this child will either refuse to go to an unfamiliar assistant during the interview and questionnaires or will not need to be distracted during the administration of the interview and questionnaires. Also, previous visits to the home have indicated that there is reason to believe that interruptions to the videotaping are unlikely.

4. There are scheduling difficulties such that sending two visitors would lead to this visit occurring outside the window for the 15 month data collection.

When only one visitor is sent to the home, this is documented on the Home Visit Report (form 15X) which is sent to the DCC.

IV. CONDUCTING THE FIFTEEN MONTH HOME VISIT

A. Window for Data Collection

The windows for each visit at 15-Months go as follows:

<u>Visit</u>	<u>Ideal Time</u>	<u>Regular Window</u>	<u>Exception Period</u>
15 Month Lab Visit	The Week Before 15-Months	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
15 Month Home Visit	The Week Before the Lab	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
15 Month Child C. Visit	The Week Before 15-Months	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days

The 15-month home visit will be scheduled and occur within

one month of the child's 15-month birthday. For example if the child's birthday is August 15, the scheduling window will be July 15 to Sept 14, even though this window may be more than 60 days. Every effort should be made to complete data collection within this window.

If, however, the visit must be canceled for some reason or cannot be completed and must be rescheduled, you may reschedule at a later date, up to but not including the child's 19-month birthday. Data collected after the child's 16-month birthday should be flagged as collected during the "exception period" by completing and sending an "Exception Period Data Collection Form" along with the data to the DCC.

Although it is preferable for the home visit to precede the child care and lab visits, this may not always be possible.

B. Equipment Needed for Visit

You may want to carry all the forms and materials in a canvas tote, arranged in order. You will want to bring additional copies of the forms, in case anything happens to this set or the father is present and wants to look them over or complete them. Be sure to take the mother's full name and address and phone number, in case you need to contact her on your way. This information should be recorded on the face sheet of the interview form before leaving for the visit.

In addition to the HOME, Interview, and Questionnaire forms, you will need the following:

1. Map
2. Directions
3. Writing board
4. Several #2 pencils
5. Extra interview and questionnaire forms
6. The response cards
7. The Questionnaire Log
8. The Interviewer Report Form
9. The Observation Report Form
10. Some large self-addressed stamped envelopes in case the mother needs to mail some forms (see Unusual Circumstances section).
11. Tape recorder (audio) and Microphones, if reliability of HOME and Interview are to be checked
12. An envelope to put completed data in
13. Subject payment and a receipt book for subject payments or forms to sign for obtaining payment (method of payment determined by sites)
14. The Home Visit manual
15. Videocamera, tripod, battery pack, and remote microphone (if necessary)
16. Erasable marker board to film identification of subject at start of videotape
17. Two blank videocassettes
18. The set of toys in a tote bag for the videotaped

interaction

19. A second set of toys if young siblings will be present
20. Postcards to notify lab as address changes occur
21. Directions for the mother to get to the laboratory and maps, if necessary, or information about how to arrange transportation to the lab
22. Information for the mother about parking at the lab
23. A card for the mother with the date of her lab visit and the telephone number of the lab
24. A medical directory or selected pages from a telephone book to look up medical providers' addresses for the otitis media information.

A checklist for common protocol materials has been included on the face sheet of the interview form. Each site may also want to develop a checklist which includes both common protocol and site-specific materials so that Visitors can easily prepare for each home visit.

C. Pre-Visit Preparation

A phone call will have been conducted after the child becomes 12.5 months that gathers child care data, and either at this call or a subsequent one, the 15 month home visit will have been scheduled.

One to two days before the scheduled visit the mother should be recontacted to verify the time and date of the visit. If the mother does not have a phone, she should be recontacted in whatever manner has been previously arranged so that she receives

a reminder within two days of the visit. If visits are scheduled more than two weeks in advance, mothers may have difficulty remembering their appointments with us. Sites may want to send the mothers reminder postcards 7 days prior to her scheduled visit.

At the confirmation call, your site may want to let the mother know that we will be asking her about the people who provide medical care to her child, and telling her that she may want to have the names or telephone numbers of her child's medical providers handy for our visit. If this is done, it is important to remind the mother that we will be interested in finding out from the medical care providers more detailed information ONLY about the child's ear infections and upper respiratory infections.

Before going to the home there are at least two things to do to prepare for the visit. First, the primary visitor should check a map to make sure that the directions received from the mother are correct. Checking the map will also help the Visitor plan the time she needs to find the mother's home and to anticipate delays. Second, the Visitor should check that all equipment is functioning properly, and all necessary supplies, materials and equipment are packed and ready to go.

D. Sequence of Procedures During Visit

1. Ideal order

The ideal order of administration or completion of forms is

as follows:

- a. HOME Inventory
- b. Mother-child videotaping
- c. Videotaping Record Form
- d. Interview and Questionnaires (& questionnaire log)
- e. Give the mother the MacArthur, explain procedures for completing and returning it at the Lab Visit, and complete the Ear Infection Data Collection Forms.
- f. Post Visit Interview With Mother
- g. Post Visit Ratings of Mother and Child
- h. Complete Interviewer Report Form and be sure Questionnaire Log is fully completed

This order should be followed wherever possible. If you alter the sequence of assessments from the planned order (HOME, videotape, interview and questionnaires), note this on form 15X, Home Visit Report.

2. When the order can be changed

Despite attempting to schedule the visit when the toddler is awake, it is possible that the child will be asleep when you arrive. If that is the case, it is better to start with the Interview and Questionnaires than the HOME, which requires observations of the mother and toddler together. If the mother expects the child to continue to sleep for a long time, administer the interview and questionnaires. If the child does

not wake up when you are finished the interview and questionnaires, you will need to reschedule the visit. If the mother anticipates that the child will need to nap very shortly (within the hour), then you should start the visit with the videotaped observations after first spending a little time in casual conversation, followed by the HOME and then the Interview and Questionnaires. The guiding principle is that the child must be awake for the HOME and awake and alert for the videotaping, regardless of order of assessments.

Occasionally, it may be beneficial to interrupt the interview if the child becomes alert after a period of sleepiness. A secondary consideration is that doing the HOME first provides a friendly warm-up for the other assessments.

E. Arrival

1. Establishing initial rapport

Upon arrival at the mother's home, offer a friendly greeting, ask how everything is going, etc. For example, "Hello Mrs. SURNAME, I'm VISITOR's NAME from the Early Child Care Study at YOUR SITE and this is VISITOR TWO'S NAME. It's nice to see you again (if previously seen). I appreciate your letting us come out and visit with you today. How has everything been going for you and CHILD?..."

The child is likely to be present. You may want to say something nice to the mother about the child, but you may not want to talk directly to the child just yet. Be sensitive to the child's need to engage you.

2. Giving an overview of the visit

After introductions, convey something like the following script to give mother an overview of the visit:

"As (give the 13 mo. phone caller's name) told you, this visit will be similar in some ways to the one we made when CHILD was 6 months old. It will probably last about 2 hours. In general we will be trying to get some information about CHILD's experiences and activities. Next we will set up the videocamera in a place in your home that will be good both for videotaping and for you and CHILD with some special toys for about 15 minutes. I'll give you more specific details about what we'd like for that part a little later. Following this, I'd like to

sit down with you again to ask you some more questions about your family's health, your employment, and CHILD's activities. Then I'll ask you to fill out some questionnaires similar to those you filled out last time. As before, everything you tell me will be strictly confidential."

(If there are site specific tasks, describe these here as well.)

"If you think CHILD is going to be content for awhile and not need to nap or eat soon, then I'd like to get started first by talking with you about some of CHILD's experiences."

If CHILD is napping when you arrive or mother indicates child is sleepy, add the following:

"(If you think CHILD is likely to fall asleep or need to nap fairly soon/since [he/she] is sleeping now) we can rearrange the order that we do things. (We can start filming right now if you think that will work out better./We can work through all of the interviewing and questionnaires first and hope [he/she] wakes up.)"

When mothers or other household members ask for more detail about the study or about what questions we are trying to answer, try to rephrase the information in the consent form or consult the information at the end of the Two-Week Telephone Interview. If people press for more information than you have, or if they ask for information which may prejudice the mother about the purpose of the study, tell the person that you are not sure what the answer is at this time, and that you'd like to check with the

Director of the Project and get back to her. Never say "I don't think I'm supposed to tell you that," or "I'm not sure if I can tell you that." Families have the right to be fully informed. If you can't answer all of their questions, let them know that you will promptly get back to them with an answer.

Mothers have already had two home visits, so they may pretty much have our routine down. Nevertheless, you are in charge and you will want to program the visit smoothly.

3. Getting down to business

Next, ask the mother where would be the most comfortable place to talk with her. Ask the mother if she is expecting anyone to come over in the next couple of hours. Sometimes mothers will have someone drop by (i.e., the diaper company, her mother). If you know this will happen, you may be able to minimize its disruptiveness.

Anticipate that phone calls may cause interruptions. Ask the mother how she would like to handle things if the phone should ring. Ask the mother if she would mind letting the answering machine (if it appears likely that one might be in the house), or if she would mind letting the father (if appropriate), get the call. If neither one applies, ask if the second visitor (if present) can answer the phone. See specific instructions in Section 15.5 (Videotaping Section).

4. Handling the presence of the father, other adults, and children (other than target child)

There will be cases in which the mother's partner or someone else will be at the home when you arrive. Tactfully tell the father that he does not have to remain present through the first parts of the visit. If the father does not take the hint or really wants to observe the interview, be gracious. During the videotaping of the structured interaction, however, you will need to request that he leave the room.

If the father remains present during the HOME you will need to tell the father again that you must ask the questions directly to the mother even if they involve him. For example, you might want to say *"We usually do not have the benefit of having fathers present during our visits, so the interview has been designed for the mother to answer all questions, even those directly dealing with you. To be consistent, I must get all of the responses from your wife/partner. You may, however, want to let me know if we are missing something."* Repeat this as often as it is appropriate. If the father does give you information, be sure to record the mother's response unless the father interjects more accurate information about objective questions pertaining to him (e.g., occupational title). Never, however, ask any questions directly of him.

If the father is not a participant in the study, he may look over the questionnaires if he wishes. Be sure to thank him for his interest in the study.

If father is a participant in the study, follow the HHS group protocol in dealing with his presence.

If other siblings are present, follow mother's lead during the HOME Inventory (i.e., they can be present or not, at mother's discretion). However, siblings should be occupied elsewhere during the videotaped interaction and the Interview and Questionnaires.

F. Audiotaping the HOME and the Interview for Reliability

If this particular interview is to be audiotaped for reliability purposes, it might be best to next ask the mother if she minds having her interview taped. The researcher may want to say something like, "We often need to tape our interviews to make sure that all of our researchers are following the same procedures. Only researchers on the project have access to these tapes. Would you mind if we taped today's interview?" In most cases, the mother will not mind, but it is polite to ask before beginning the interview. If the mother objects to the taping, be gracious and make sure that the next interview conducted by this particular interviewer is taped. (See Section 4 (the Interview and Questionnaires Submanual) for specific instructions).

G. Exiting

1. Post Visit Interview and Report Forms (See Appendix of Chapter 15.4)

For each question of the Post Visit Interview (form 15Q), do not read response choices to the mother. Instead, let her answer in her own words and code the information she gives you. Note

that these questions pertain to the entire visit, not just the videotaping. Questions 8 and 9 should only be asked to mothers who are employed or in school. We are interested in finding out the day and time the mother last arrived home from work or school, and the day and time she will be leaving the house to go to work or school again. The purpose of these items is to determine when home visits are occurring relative to mother and child separations. That is, we are concerned that an imminent separation or a recent reunion in the employed/in school mothers may affect results. Work in the home or at the office while child is present does not count for these questions.

Information for completion of the Post Home Visit Ratings of Mother/Child Behavior During Video & Entire Visit (form 15R) will be gathered throughout the visit. Question 10 refers to how much smoking was evident during the visit. The definitions for the amount of smoke are as follows:

- 0 = None
- 1 = A little - only 1 cigarette smoked in outdoor setting.
- 2 = Some - 1 cigarette smoked near child's face (within 3 feet) or several cigarettes smoked at a distance.
- 3 = Moderate - more than 1 cigarette smoked near child's face (within 3 feet)
- 4 = A lot - air is smoky during the visit.

Questions 11 and 12 also report smoking behavior during the entire visit on the part of the mother and any OTHER person present in the home.

In order to account for differences in visits the order of home visit procedures, the number of home visitors, and any unexpected variances from protocol need to be recorded on form 15X, the Home Visit Report. This form should be completed at the end of every visit.

2. Debriefing

It is important at the end of the visit to "debrief" the mother. Ask the mother if there is anything that we didn't ask about that she thinks is relevant, or if she has any comments or questions about the visit she would like to share with us. The Visitor needs to be sensitive to any negative affect in the mother and needs to give the mother a chance to share her feelings. If the mother asks questions about the research hypotheses, try paraphrasing the information for the families in the consent form and two-week phone call. This is necessary to give the mother a sense that she is an important part of the research process, to give her the chance to tell us if the visit captured out-of-ordinary circumstances, and to express any adverse feelings she may have had about the visit.

3. Paying the mother

Thank the mother for all her time and help. Explain how important this study is, and how we value her time and help. Pay her \$25.00, or make arrangements to pay her. If all of the information is not completed during the home visit and this is

due to circumstances beyond the mother's control (e.g., the visitors must leave for some reason), the mother should be paid before leaving the home. If, on the other hand, the mother cuts short the visit before completing all of the measures, then she should be paid when her complete information is received. Please consult the Unusual Circumstances section in this manual for other payment issues.

4. Preparing for the next contacts

If the mother has not yet had her 15-month lab visit, the most important order of business here is to confirm the time and date of that visit and go over with the mother information about how to get to the lab and, if appropriate, where to park. Written directions as to how to get to the lab or how to arrange for transportation may be necessary at some sites. Remind the mother that someone will call to confirm the time and date of the lab visit on the day or two before the visit. If the mother tells you that the scheduled lab time is no longer convenient, either reschedule her on the spot or tell her that someone from the lab will call to reschedule.

Mothers may want to know what will happen at the lab. You may tell her that we will be observing her child playing first while she is present and later, while she is in another room for a few minutes. At all times, she will either be with her child or able to view her child through a one way mirror. We will also have some special activities for CHILD, and we will watching to

see what the child does. If the mother has already had her lab visit, say something like:

"The next time we visit you in the home will be when CHILD is 24 months old. On that visit, we will simply be observing CHILD and you as you are naturally, here in your home. We will ask you the questions and have you complete the forms while your child is playing at the 24 month lab visit. We will contact you a few weeks before CHILD is 24-months old to talk with you about the details of these visits. If at 24-months CHILD is in (still in) some form of regular child care, we would also like to visit her while she is there. When we call you to arrange our visit at 24-months, we'll also want to contact the caregiver. We will (will again) pay the caregivers for their time and help."

"Someone will call when CHILD is 18-months to talk with you about whether CHILD has been sick or whether you have changed your child care arrangements".

Leave the mother a business card or some small information card with your name on it that she can file or "put on the refrigerator." If the lab visit is scheduled, be sure to have the date and time of the lab visit on the card. If the lab visit is to be rescheduled, have the original date on the card, crossed out. Say, "We'll be in touch with you, but if anything changes for you or if you want to contact us, please call. Our number, and my name, is on this card."

H. Departure

Leave the mother with a good feeling about your visit. As you leave, give the mother positive feedback along the lines of "You've really been helpful to us," "I've enjoyed meeting you, I'll look forward to visiting you again," "You really have a beautiful child."

V. POST-VISIT ACTIVITIES

A. Checking the Data

After the visit is completed, the primary visitor should look over the entire interview form and questionnaires and the HOME form, to make sure that each item was completed and coded properly. It is also recommended that the interview be double-checked by another 15-month home visitor.

B. Documentation of the Visit

To document the visit, the primary visitor will need to complete some forms after leaving the home.

1. Post Observation Ratings Checklist

The visitors will complete the Post Home Visit Ratings of Mother and Child Behavior during the videotaping and the entire visit (form 15R). This form is used to rate each visitors' impressions of the videotaping and of the entire visit, including an overall impression of the mother-child relationship. This form is returned to the DCC.

2. Questionnaire Log

The visitor will complete the Questionnaire log sheet (form 150). In most cases, the visitor will be able to complete this form during the home visit. This form is kept at the site.

3. Interviewer's Report Form

The visitor will complete a Interviewer's Report Form (form DM-D). This form gives the visitor(s) a place to record in more detail any extenuating circumstances that may have affected the 15 Month Protocol, report the presence of unusual or maladaptive behaviors of the mother or child, and describe the mother's comments following the interview. It also affords an opportunity to record any comments the interviewers want to make about the home visit. This form is filed in the subjects' personal files at the site.

4. Log Book

We also recommend that each site keep an informal log book on each visit. Here you could include information about who the Visitors met during the visit, general comments about the proceedings, and note some non-protocol information about the visit such as things the Visitor may have discussed with the mother, the name of the family dog, etc. This information may be useful in maintaining rapport during future contacts. Be careful not to include information that may bias future Visitors; only information that may help them respond as sensitive, friendly

visitors to the family.

C. Posting the Data and Videotape

See Chapter 3, "Data Management and Paper Forms Handling" for information on posting the data forms to the Data Coordinating Center.

After making a copy, the original videotape of the 15-minute structured interaction should be labeled and mailed directly to Margaret Tresch Owen (see instructions in Section 15.3, Videotaping section).

D. Maintaining Rapport

Each site will send some type of thank-you note to the families after both the home and lab visits are completed. Each site can decide the form of the note with which they feel most comfortable. All sites will send the children yearly birthday cards. Each site can also decide whether they want to send holiday cards.

VI. ENCOUNTERING UNUSUAL CIRCUMSTANCES

Listed below are some situations that may be encountered on the 15-month visit and our suggested solutions. We realize that each site is different and we invite your comments and suggestions.

1. The Visitor arrives and the mother is not home. Do we call and reschedule her?

Before leaving the area, the Visitor should attempt to call the mother from a nearby phone booth to make sure that she really is not home (e.g., her doorbell may not be working). If the mother is not home, the Visitor or the scheduler should attempt to contact the mother as soon as possible. Every attempt should be made to reschedule the visit within the allotted time frame.

2. The mother refuses to participate once the visitor arrives at the home. Do we pay her?

If at all possible, the Visitor should try to determine exactly why the mother refuses to participate before she leaves the home. By keeping accurate records of refusals and drop-outs, we may have some insight into the biases that may creep into our sample. If the refusal is related to specific circumstances of the day or week, then arrangements to recontact her and reschedule the visit should be made. As for paying her, we do not have to, considering that the money is for participating in the study. We should thank the mother for her earlier

participation and leave. The P.I. or Study Coordinator will want to decide how to follow up on this situation.

3. The Visitor arrives at the home and the mother says that she or the child is not feeling well and she wants to reschedule.

The Visitor should try to determine why the mother did not phone the lab to cancel her appointment. Is this a sudden illness that may have prevented the mother from contacting us? The Visitor should offer to reschedule if the mother or child was truly ill and the mother was too busy or too distracted to call us. If possible, she should be rescheduled on the spot. However, it may be that neither the mother nor her child is ill; the mother just does not want to be in the study anymore. The Visitor should verbally check this out with the mother. If the mother does not want to be rescheduled, the Visitor should thank the mother and politely leave. Tell your SC or PI of the circumstances when you return to the lab/office. The mother will be called and rescheduled if possible.

4. The house we are visiting is chaotic, noisy, etc. There does not seem to be a place to do a quiet interview or a videotape session without many interruptions. What do we do?

This should occur infrequently because strong efforts to minimize disruptions should occur during the scheduling of the visit. However, if the situation arises and the mother seems very eager and cooperative, we should ask her if there is a

better time to reschedule the visit if there is absolutely no way to get through the visit. You may decide that since this is a longitudinal study, it is best to collect these data under less than optimal conditions in order not to lose the opportunity to see this family at this data collection point. For further information about what to do about videotaping the three bag task under difficult conditions, see information in Chapter 15.3.

Almost any interview can be gotten through despite interruptions. It is best to plan ahead for these interruptions by leaving ample time in the Visitor's schedule to complete the visit. It is also the case that 1-month and 6-month visits were completed with this family, making it probable that a 15-month visit will be possible with perseverance and two thoughtful and sensitive visitors.

5. The mother is very hostile, uncooperative, high, etc. What do we do? Will we see her again?

If the mother is merely uncooperative or somewhat hostile, the visitors may want to switch gears and allow the mother to do more open-ended talking for a while. If this does not help, one of the visitors should reassure the mother that her participation is strictly voluntary and that if she finds the questions or procedures in any way a problem, she can withdraw at any time with no penalty. If the mother is being uncooperative by refusing to answer any questions, the Visitor can reassure her that all information is held in the strictest confidence. Keep

in mind, however, that it is the mother's free choice whether or not to answer particular questions.

If the mother is overtly high or psychotic, the Visitor should leave the house as soon as possible, as tactfully as possible. The Visitor can skip through the protocol to go to the end and ask a few final questions. If the mother asks why the questions are being skipped, she can be told that they are not applicable to her situation. Data from the 15-Month Home Visit will be missing in this case, but the mother will be contacted again at the next scheduled data collection.

6. What if the mother wants to change the order of the questionnaires she completes?

The Visitor should tell the mother that we need to keep things standardized and that we need to keep the forms in their original order. If she is resistant, allow her to complete the forms her way. Indicate on the protocol that the order was changed and how.

7. What if the mother asks to fill out the written sections at another time and offers to mail them in?

If you have finished the interview you may leave the questionnaires and a self-addressed stamped envelope for the mother to mail back or bring with her to the lab visit. Ask the mother to complete the forms by herself in the order they are given to her. Stress to the mother, however, that you will need

to receive the forms within the week. Call to remind her if you have not received them back within four days. If you have not received the forms within the week, call again to remind the mother. If you get the sense from this second phone call that there is some trouble in filling out the questionnaires, try to schedule a time to return to the home and help the mother work through them. If there are also a few remaining interview questions, schedule a time to call the mother to complete these questions over the phone. This call should be made within the next working day, if possible.

8. What if the mother has the following reservations about your contacting her doctor(s) or clinic for the health information?

- a. Mother is concerned about what you will ask the doctor?

Assure her that only information on ear and upper respiratory infections will be gathered.

- b. Mother is concerned about having taken the child to several doctors and/or clinics.

Assure her that this is a common practice.

- c. Mother is concerned about not having taken the child to a physician or clinic when the child had an ear or upper respiratory infection and/or for follow-up visits.

Tell her that this is common and she should not

feel she has been negligent in any way.

- d. Mother is concerned that the child has had recurrent ear and/or upper respiratory infections.

Assure her that recurrent ear and upper respiratory infections are common in young children.

What if the mother does not know the physicians' addresses and telephone numbers and asks to mail in the form?

First, suggest that the Visitor help the mother fill out the form by looking up the addresses and phone numbers in the phone book. (It is possible that some mothers may have difficulty looking for this kind of information.) If the mother still prefers sending in the names and addresses of the doctors and clinics, give her a self-addressed stamped envelope and ask her to return the form within the week. Call and remind her if the form has not been received by the end of the week.

What if the mother says she does not have a physician and asks for a referral?

Each Principle Investigator will determine a format for dealing with this problem (perhaps having a list of doctors available or some referral source to which to direct the mother).

What if the mother has moved from one section of the city to another or from one city to another?

Ask for the names of all prior physicians and clinics to which the child was taken.

9. What if we/she has to leave before finishing the protocol?

A return visit will need to be scheduled if:

- a. The HOME INVENTORY could not be completed (see specific contingencies in section 15.2).
- b. The mother-child interaction was not videotaped.
- c. If you have not completed at least half of the interview.

10. What if the visitor(s) see indicators of child abuse or potential abuse?

This information should be reported to the PI immediately. If required by state laws, this information will need to be reported to the appropriate authorities. If the family still wants to be in the study, they should still be included. This information must also be reported to the Data Coordinating Center.

11. If a child dies unexpectedly before the fifteen month visit, is it appropriate to send a card?

It is appropriate to send a note of sympathy. Each site can decide how they want to handle this situation. The Temple site would recommend sending a card which includes the phrase, "If there is any way that we can be of help to you, please let us know."

12. If the mother and her child are not living together in the same household at the time of the fifteen-month visit, what do we do?

If the legal guardian or the person who has been taking care of the child has agreed to participate at the 13-month phone call, schedule the visit with this caregiver at this person's home. Do the HOME, the videotaped interaction and the interview (xeroxed version) with this substitute caregiver. Do not drop the original family at this point--the mother and child may be reunited later.

13. What if the mother's partner is female? Do we ask all partner questions in relation to this person?

If the mother defines a woman as her partner, then all questions pertaining to partners in the Fifteen Month Structured Interview (not the HOME) should be asked with respect to this person. The Interviewer should substitute "she" for "he" wherever this is appropriate.

14. What if the mother cannot, or does not want us to visit her at home?

Arrange to send the mother the questionnaires, and to interview her on the phone. If the mother and child are living in someone else's home or in a shelter for a relatively short period of time, it would be possible to do the videotaping portion of the visit in this new setting. However, the HOME

should not be completed, as it might give an inaccurate impression of the "usual" environment of the child and mother.

15. What if the target child or sibling(s) persists in distracting the mother or vying for the mother's attention?

The second home visitor should be able to distract siblings and prevent them from interrupting the interview. A single home visitor may also be able to reduce interference by bringing extra toys for the target child and siblings to play with. Videotaping sibling(s) can also be done as a "reward" for not interrupting videotaping of the structured interaction.

VII. SAFETY GUIDELINES

Occasionally, home visitors will have to go to an area with which they are unfamiliar. In some cases, they may have to make the decision not to collect the home data at 15 months because the family's home is unsafe to visit for some reason. It is, therefore, essential that visitors be able to evaluate the safety of an area and learn how to increase their safety when traveling in unknown areas. We have compiled two lists to help visitors with these tasks. These indicators are only imprecise guidelines. The presence of these indicators does not necessarily mean that the area is unsafe, nor does the absence of these indicators necessarily mean that the area is safe. These are meant only as indicators to consider. Sometimes visitors will have to go on their 'gut reaction'. Remember -- the safety

of home visitors is paramount! Never enter or stay in a situation in which you feel threatened.

A. Things to consider in evaluating the safety of an area.

There are three significant characteristics of dangerous areas: isolation, evidence of drug use or criminal activity, and a general air of abandonment. Remember that the presence of these characteristics do not always indicate danger, but they are signs that should be attended to. Some indicators of dangerous areas include:

Isolation

Poorly lit areas

People walking around with no apparent destination

Closed down industrial or business establishments

Nobody to go to if there is a problem (i.e., areas with boarded up homes, closed businesses or industrial firms)

Evidence of drug use or criminal activity

Lots of graffiti

Adults and teenagers loitering on street corners during the day

Prostitutes standing around on corners

Crack vials and syringes on the street

House with lots of people going in and out

Abandoned or boarded up buildings

Unkempt homes: Broken windows, homes in need of extensive

repair

Area with many boarded up homes

Many old or abandoned cars

More trash than normal

The appearance of any one of the above characteristics does not mean that an area is unsafe. However, if you notice several of these characteristics, and you have a gut feeling that you should not be in that area, it probably means that the area is unsafe.

B. How to Increase Your Safety

1. Dress casually, in flat shoes, with no jewelry. (A casual watch is fine.)
2. Do not go into a possibly unsafe area alone.
3. Have exact directions to the home. Tell the mother that you are unfamiliar with the area and ask her exactly where to park the car.
4. Arrive early to a neighborhood to check things out. If you give yourself plenty of time then you will be better able to make an evaluation of the area.
5. Carry minimal equipment in a canvas tote.
6. Don't carry a purse.
7. Don't leave anything in your car. If your car has a trunk, try not to keep the equipment in there. If you are seen going into the trunk, someone may suspect that you have other things in the trunk.

8. Look like you know where you are and what you are doing. If you look intimidated, you are more likely to be the target of crime.
9. Make sure that someone knows the time of your visit and the time that you are expected to return.
10. Keep in contact with the local police precinct. They can answer many questions you may have about an unfamiliar area.
11. Try to schedule the home visit during daylight hours.

C. Dealing with Unusual Circumstances From a Safety Perspective

1) If the visitors arrive in front of the house and decide it is too dangerous to get out of the car, or the house looks "too questionable to enter", the visitors should get to the nearest safe phone booth and call the mother to tell her that they are not coming. In cases where the visitors know that they are going to a borderline neighborhood, they should arrive early to check out the situation. This way they will also minimally inconvenience the mother because they will call her about the time they should have been arriving rather than leaving her waiting. In this case, it may be better not to tell her the truth about our fears of her house and neighborhood because this may be inaccurate and unkind. Visitors could tell her that something happened and they couldn't get to her house. Although we did not reschedule when the situation was too dangerous at one month, we will attempt to handle these circumstances differently

at 15 months, since this is a longitudinal study. We now have considerable data and time invested in this family. Reschedule the visit and enlist help from security or police personnel to enable you to make the visit on the next try.

If you know from previous visits that the home is in a dangerous neighborhood, you should check out the area at least 48 hours before the scheduled home visit as was done before the 1 month visit. If you see that the neighborhood does not at this time meet the criteria for "safe," make arrangements to have the help of security or police personnel to get from your car to the home and back. If you cannot obtain help to make the visit safely, then cancel the appointment and attempt to collect as much interview and questionnaire data as possible over the phone and through the mails. Upon receipt, send the mother a check for \$25.

2) If the visitors enter the house and decide that the situation looks unsafe: If the situation looks extremely unsafe (see safety regulations) as the visitors enters, the visitors should leave the questionnaires and arrange to visit the mother at another time. For the next visit, the visitors will need to arrange security or police protection. Upon receiving the questionnaires, send a check for \$25.

If the visitors enter a situation which appears okay at first but later becomes dangerous, they should leave as soon as they can and as tactfully as possible without compromising their personal safety. As they leave, they can briefly explain that

this looks like a bad time. As above, leave questionnaires and arrange for a phone interview. Pay the mother upon receipt of questionnaires.

If the visitors decide not to see a family on the basis of safety, or if they should leave before the interview is completed, they should report this to the Study Coordinator and Principal Investigator. In addition, the visitors should document why and how they arrived at the decision to terminate the home visit so that a written justification, based on each site's guidelines, can be sent to the Data Coordinating Center. (See the Safety Exclusion Form, in Appendix D of Chapter 6.1.) Some suggestions on developing site-specific safety guidelines are contained in Appendix G of Chapter 6.1.

VIII. OVERVIEW OF TRAINING

The 15-month home visit consists of several different components. Training guidelines for each of those components are included in the appropriate Sub-Manuals. This section reviews procedures for general training for visitors.

In addition to their training on the various components, visitors will need training in the general flow of the visit and in responding to the kinds of situations that may come up. It is also helpful to review the place of the 15-month visit within the context of the full study. For example, this is our third home visit, but it is the first opportunity for the mother to come to the lab; mothers may have a variety of concerns. Families' lives are changing. Many more mothers will be back at work. The children are past the unsettled first year and are beginning to walk and explore the world on their own, testing limits, and in some cases, patience. The youngsters are interacting more and more with others, and they will be more curious about you and your equipment than ever before. Siblings are probably more accustomed to the changes that the child has brought, but they may be increasingly jealous of the increasing attention this newly walking and exploring toddler attracts. And there may even be a new baby in the house! By the time of our 15-month visit, the study is nearly half over, and mothers will be beginning to see you as a part of their "extended" family.

While each research assistant will have copies of the portions of this manual that are relevant to his/her tasks, we

have also found the following materials helpful for visitors, and we recommend that each site prepare them ahead of time for your visitors. These one-page "crib-sheets" serve as quick checks for the research assistants before each visit.

1. A master list of all the materials needed for all the components in the 15-month visit, plus any site-specific materials.

2. A 1-page list or flow-chart of the sequence of the components, which visitor does what, and what the visitors will have at the end of the visit (completed HOME checklist, completed interview and questionnaires, videotape of structured interaction, etc.)

Representatives from each site will be trained on the components of the 15-month home visit on February 29 through March 3, 1991 in Philadelphia. (Philadelphia is an exciting city, with great restaurants and fun things to do while we hone our skills.) Visitors will be expected to be familiar with the 15-month home materials and to have done 3 to 5 home visits. Videotapes will be required. (More specific information will appear in December 1991.) Those who receive training in Philadelphia will be training additional visitors back at their sites. Once all the participating visitors are trained on each of the components, they should practice putting it all together at their sites. Home visitors will need to make a number of visits, probably to the pilot families, during which they do the entire sequence of components "for real", before they start

visiting the 120 official families. Criteria for "certification" of home visitors are described in the submanuals.

Additional Monitoring Instructions

General Considerations:

The purpose of the Interviewer Monitoring Form is to document the reliability of the interviewers conducting the Standardized Interview and Questionnaires as part of the 15 Month Home Visit. At 15 months, these forms will be sent to the Data Coordinating Center after they are completed by a certified monitor at each site. They will be stored at the DCC as a permanent record of interviewer reliability.

Each form that is required to document the reliability of the interviewer must be sent to the DCC. This includes forms on the first two non-real subject interviews used to certify the interviewer, the first two "real" subjects, and the first interview of each month after the initial certification. In addition, if an interviewer does not pass reliability at any point, forms on the first two "non-real subjects" used to recertify the interviewer and the first two "real" subjects must also be sent to the DCC. A copy of all of these forms must also be kept at the sites.

The monitoring form itself is not devised to provide extensive feedback to the interviewers. For example, only violations of reliability should actually be recorded on these forms. Interviewers need to know both what they do incorrectly and those things that they do well. Therefore, while monitoring provides an excellent occasion to give feedback to the interviewers, we suggest that the monitor also make more extensive notes than those recorded on the actual monitoring forms to share with the interviewers. Also, while monitoring is required on a monthly basis, interviewers may desire feedback at shorter intervals. (Some sites tape all of their interviews so that each one can be gone over if the interviewer has particular questions about certain interviews.) In addition, it is strongly recommended that each interviewer be made as knowledgeable as possible about the actual monitoring procedures, even if they are not certifying to become a monitor of other interviewers. The more explicit and clear these monitoring criteria are to the interviewers, the more they will understand what it is we expect from them.

Some changes have been made to the monitoring procedures at 15 months. These changes are the product of feedback received from interviewers as well as from inter-site communication regarding these procedures. These changes are, in part, an effort to foster greater consistency across sites in the implementation of these monitoring procedures. Some of these changes seem minor but there are some important differences between the six and fifteen month monitoring procedures. Thus, monitors that were certified at six months must learn these changes and must recertify at fifteen months.

To facilitate the process of becoming certified monitors, we have developed detailed instructions regarding the use of the monitoring form. (These instructions supersede the instructions you received with the tapes). Because the Six Month Interview and the Fifteen Month Interview differ in some subtle yet important ways, we also point out where some of these differences may lead to errors on the administration of the 15 Month Interview.

If you have any questions regarding the general monitoring procedures or questions about how to use the monitoring form, please feel free to contact Wendy Robeson.

Instructions on the Use of and Scoring
of the Interviewer Monitoring Form
Lyz Jaeger and Wendy Wagner Robeson

Each category will be discussed as it appears on the monitoring form.

1. READS

This category has lead to the greatest between-site differences in the use of the monitoring form. The following things should be noted in this category:

a. The interviewer reads every question as it is worded, every time she asks the question (unless the interviewer is "confirming" -- see below). On re-reads, interviewers often don't repeat the whole question and they should be deducted points for this each time it happens.

b. The interviewer should read all response choices every time she has to read the options to the mother. Interviewers frequently make the mistake of only re-reading the options which seem closest to what the mother is saying. (This particular type of mistake also borders on becoming a directive probe, but will only be counted under "READS.") Points should be deducted every time that this occurs.

c. Also included under this category is how the interviewer states the information in parentheses. There are several different types of information in parentheses:

1. If CHILD/HUSBAND etc. is in parentheses, the interviewer should read the proper name of that person. Points are not deducted for saying 'your child' instead of the name but if the interviewer fails to say the name consistently, it should be noted to the interviewer.

2. If the information in the parentheses is a definition of the intent of the question, then it should be read to every respondent and should be read exactly as it is written when the question is first asked. For example, see Section I, Q# 23. Points will be deducted for not reading this information exactly as it is written.

3. In several cases, information that may or may not be relevant to a particular family is printed in parentheses. This information must be read if it is applicable to a particular family or else points will be deducted. For an example of this type of case, see Section I, Q# 26.

4. In many questions, the parentheses call for the Month of the last visit or call. A change that will be made in the manual will instruct interviewers to say, "...when we last visited/spoke with you" or "Since I last came to see you in _____" EVERY time the question states "Since MONTH". So the correct way of asking a question that begins with this phrase is: "Since May, when we last spoke with you,..." or "Since I last spoke to you in May". It is also acceptable to include the exact date of the last contact. The interviewer can refer to the exact date the first time the questions in a section include the word MONTH, as well as with the following one or two questions. However, after the first two or three questions, to include the exact date with every following question may jeopardize rapport and points should be deducted. If the mother asks when the last contact was made, then the interviewer can include the exact date when she re-reads the question. In addition, interviewers will be instructed to give the actual date of the last call or visit at the very beginning of the standardized interview and questionnaires.

d. Adding words to the question, especially in the middle of the question or at its end, counts as a violation of "READS" and points should be deducted for it even if it seems trivial. Sometimes, however, some questions can be prefaced in a way which does not count as a violation of "READS". For example, adding the word "And" to the beginning of the question or making a transition statement to a group of questions which has a clear ending before the question is asked (e.g. "This next set of questions also deal with your employment situation". "How many of your...") If the statement prefacing the question could conceivably alter the meaning of the following question, then it should be counted against reliability.

Interviewers are expected to make their own transitions between sections.

e. Omitting words should be counted as a violation of "READS" even if it seems very minor. For example, interviewer frequently left the word "up" off of Section I: Q:26. While this word does not change the meaning of the question, it does change the way it sounds and may affect how the mother hears the question.

f. The way the interviewer introduces each QUESTIONNAIRE section and each individual questionnaire will be monitored under "READS". While the interviewers do NOT have to read these scripts exactly how they are worded, they must convey the same information every time they say these scripts. The following information must be given:

1. Introduction to Section: Each time the interviewer introduces the transition to the questionnaire portions, they must tell the mother at least three things: 1) She may have seen some of these questionnaires before, 2) She should

answer these questions about how things are at the present time or how she feels right now and 3) she can ask the interviewer for help if she needs to.

2. Introduction to the Scripts: Each time the interviewer introduces a specific questionnaire, she must tell the mother two things: 1) The content of the questionnaire and the applicable time frame if there is one (see, for example, My Feelings), and 2) that she should read the instructions at the top of the form before she begins. These things must be said before each questionnaire or points will be deducted.

Frequent errors include such things as reading the actual instructions printed on the form to mothers, pointing out potential difficulties with particular questionnaires, and forgetting to ask the mothers to read the instructions before they begin. Interviewers should not be giving any more information than that stated above UNLESS the mother explicitly requests it.

g. Interviewers frequently fail to read the Work Update prompts exactly as they are written. Points should be deducted if they fail to do so.

h. The transition sentences in the interview do not have to read exactly as written. However, some sentences that used to be part of the transition scripts are now part of the question. See, for example, Section I: Q31 and Q35. These statements should now be read exactly as worded because they are now part of the question and if they are not read as worded, points should be deducted for reliability.

i. Frequently interviewers are treating the introductions to Section II: Q#26,27,28 as optional introductions. These must be read exactly as worded or else points should be deducted.

j. While it is useful to note every instance in which the interviewer has not read every question exactly as is written (except where they otherwise confirmed the information), the following do not count as errors under READS:

1. If an interviewer reads two words as a contraction rather than as two separate words, no points will be deducted. Be especially careful, however, that the interviewer does not inadvertently change the tense of the sentence. If this happens, points should be deducted for reliability.

2. If an interviewer prefaces questions with a word like "And" OR "Next". If the interviewer does this frequently, it is worth noting to the interviewer but will not count against reliability. Be careful, however, that the interviewer is not inserting words before the question that may alter its meaning. For example, adding "On Average" before a question changes the meaning of that question EVEN IF that is what is the implied intention of the question. If the respondent needs help remembering that something is "on average", the interviewer should read the question as is, and then "step outside of the interview" to clarify that the question is about "on average".

3. Changing prepositions such as "spoke to you" versus "spoke with you" does not count against reliability.

4. Changing articles such as "this" to "that" will not count against reliability.

5. Inserting the word "that" after the words "Would you say" will not count against reliability. See, for example, Section I: questions #31 and #35.

6. In Section II: Question #1, we would like interviewers to stop asking the part of the question "Have you started or stopped working at any jobs?". If they end up reading the whole question, do not count it against reliability.

7. In the Work Update prompts, the TAXES prompt may be read "Is this before taxes?" and no points will be deducted for reliability. This change was made because the question printed on the grid is not consistent with the question on the prompt sheet.

8. In Section II: Questions 23-28, points will not be deducted if interviewers do not read the phrase "Please choose one of ..." exactly as it is written.

9. And as already mentioned above, points will not be deducted if the interviewer says "your child" in the place of the child's name when the question states "CHILD".

There has been considerable controversy regarding how much and when interviewers should adhere to the "READS exactly" rule. Remember, interviewers can choose to CONFIRM (see below), "step outside the interview", TRAIN the respondent, and PROBE. All of these make the interview more "friendly" and accurate. If you have interviewers who are making consistent READS errors which you think are trivial, please discuss them with Wendy Robeson.

It is rare for interviewers to have flagrant violations of this rule. Usually the mistakes are small, such as omitting or adding one word to the sentence. Even though these mistakes can look small, they often have subtle, yet quite conceivable,

implications for the meaning of the question. While this rule may seem strict, it is important to note that many interviewers easily get to the point where they do not commit these errors and even if the commit four of these types of errors, they still pass reliability!

2. CONFIRMS

The only errors that are to be recorded here are those made when a question is confirmed rather than read exactly as it is written. Some people have put failure to confirm errors under this category but that is not the intention here. What we are really concerned with under "Confirms" is WHEN the interviewer does use confirmatory statement, do they use the meaning containing words in the original question.

A frequent error made by interviewers is that they attempt to confirm a mother's answer before they have enough information. Any case where an interviewer does not have full, clear information from the mother prior to asking the question, they should NOT confirm. If they do, this becomes a directive probe error and should be recorded as such.

A common mistake noted so far on the 15 month Interview is that interviewers are frequently confirming whether or not the mother moved since the 6 month visit. They are assuming that if the mother is at the same address, that she has not moved. This is incorrect. She easily could have moved and moved back in again since that time. This error is scored as a PROBE error since it is a directive probe.

Interviewers were told at the training that if they are confirming a question because of information they heard prior to the Standardized Interview and Questionnaire portions of the visit, they should repeat this information before they confirm the question so that the monitor will know that the interviewer actually had this information. For example, if you find out earlier in the visit that the husband is not longer employed, the interviewer could say something like, "When we were talking earlier in the visit, you mentioned that your husband is not now working for pay."

3. DEFINES

This category refers to definitions that the interviewer gives the mother during both the interview and the questionnaires. Errors to be included in this category include offering definitions of subjective phrases to the mother, giving incorrect definitions of words for which the interviewer is allowed to give a definition, not giving the manual definition of a word if it is defined in the manual, and failing to note definitions given on either the Questionnaire Log or the Interviewer Report Form.

4. RECORDS

There has been confusion over the use of this category and the "CODES" category. Errors noted under "RECORDS" generally refer to recording errors on questions where the interviewer must record exactly what the mother tells her in the form of pre-existing Scantron bubble choices. The interviewer has to make no coding decision on these types of questions.

Common problems with the 15 month Interviews were that interviewers forget to fill in the NA box for the secondary job in Section II: Question #2 and they also failed to fill in N's on Section I: Question #22 where applicable.

5. CODES

This category refers to questions where some coding decision is required by the interviewer. These questions are generally asked as open-ended questions and the interviewer determines which Scantron answer represents what the mother has said. The relevant items on the 15 Month Interview are: Section I: question #22 - 4c, 4d; question #23; Section II: Occupation code on Work Update, question #13, question #22). (Also, if Section I: #22 is asked simply as an open-ended question and answers are not confirmed with the mother, then errors in coding would also be noted here.)

The interview also calls for the recording of information that is not in the form of a Scantron answer. There are many places in the interview, for example, that ask the interviewer to "Specify". Although these answers may not seem as important as the Scantron answers, the answers to these questions should be recorded clearly and in a form that would be interpretable by someone other than the interviewer. If the interviewer consistently fails to record such information clearly over the course of the interview, count this as one instance of a disagree.

6. FAILS TO PROBE

A difficulty in noting these types of errors on the monitoring form is that they are likely to be confounded with recording or coding errors. Interviewers make coding and recording errors often because they do not have enough information, i.e. they failed to probe where it was appropriate. For purposes of the monitoring form, we will not double code interviewer errors. If a recording error is really the result of a failure to probe, record it only as a failure to probe. (If the recording error is the result of some other problem, record it under "RECORDS".)

Common probing errors include the following: 1) not getting sufficient information to record the mother's response exactly in the form that the Scantron options call for (for e.g. coding a Y

or N response when the mother has not actually said either yes or no), 2) not probing "Anything else?" on all open-ended questions (such as with section I, questions 36-40) -- failure to probe with one question will not result in deducted points but failing to do this twice will count as one failure to probe error and 3) not resolving factual contradictions during the course of the interview -- each error of this sort should be noted.

7. PROBES

Directive probes include any questions that may prejudice the mother's answer in any way. For specific examples, please consult section 15.4 of the Home Visit Manual.

There are other types of inappropriate probes that are not necessarily directive. For example, if an interviewer asks a mother the same question twice and the mother has previously provided an answer that fits into one of the acceptable response options, re-asking the question is an inappropriate probe. However, if the interviewer has clear evidence (i.e., an answer to an earlier question, the mother's statement that she doesn't understand the question or is unsure of her answer), repeating the question is often the best approach. Put simply, if interviewers have "evidence" of inaccuracy or confusion, it is okay to repeat a question. If they don't have evidence, they shouldn't repeat "just on a hunch".

All instances of directive and inappropriate probes should be noted in this category.

8. SKIPS

Several different types of errors should be noted under "Skips". Failure to follow skip patterns, and failure to ask or confirm any single question that should have been asked are all included under "skips".

An interviewer should generally not be penalized for getting too much information. The only exception to this is when the interviewer asks questions about a husband/partner when the mother does not have a live-in husband or partner. Asking such questions is likely to compromise rapport.

A question which many interviewers have had is whether a skip problem that is soon corrected by calling the mother and getting the missing information should be counted against reliability. The answer is yes, these errors, even if soon corrected by the interviewer count as a "SKIP" error. The interview is meant to be given in person, not over the phone. Also, calling the mother back is another imposition on her time which we should seek to avoid. IF, however, the interviewer catches their skip error before leaving the home and records these questions being asked of the mother, it should NOT be counted as a "SKIP" error.

One common problem noted with the 15 month interviews is that interviewers were failing to confirm the relationships of the household members to the mother and baby. If these are not confirmed, it should count as a skip error. Another common problem is that interviewers fail to confirm information especially when the mother answers the question in her answer to the previous question. Even if this happens, the interviewer is expected to confirm the information rather than to skip the question altogether. This is especially common with Section I: questions 20-22.

9. FEEDBACK

Interviewers must seek to avoid saying anything to the mother which may make her conscious about what the interviewer feels or thinks. Anything which conceivably could compromise the neutral context of the interview will count as a feedback error.

Several problems are common in this domain. First, interviewers still use words such as "O.K.", "Alright", etc. as filler between questions. While we are certain that many times mothers would not interpret this as an interviewer's evaluation of the mother's answer, we can never be sure that she won't interpret these words in that way. Thus, they are better avoided. (Also, when an interviewer uses these words repeatedly, she can sound as though she is cutting the mother off from offering additional information and trying to rush her through the interview).

A second problem that is common is that interviewers frequently want to say positive things to the mothers, particularly after they have expressed delight about something. For example, mothers are often happy to report that their babies had no health problems. Interviewers are likely to respond with statements such as "That's great". Unfortunately, what this seemingly nice comment may be doing is telling the mother that the interviewer would much rather hear about positive things rather than negative things such as health problems. Perhaps the best thing that an interviewer can do when a mother expresses delight or happiness is to "match" the mother's affect. For example, if the mother is smiling, the interviewer may smile too.

A third problem that interviewers have encountered is what to say if the mother expresses something that may seem very sad. In these circumstances, interviewers often want to offer words of sympathy. While this may seem like the polite and rapport-building thing to do, in some cases, the last thing the mother wants is for the interviewer to focus in on the issue by saying something about it. And, again, if the interviewer appears sad by what the mother has told her, the mother may censor other responses so as to not affect the interviewer's feelings. As with happy news, it is appropriate to match the mother's affect. If she appears sad, its okay to say "I;m sorry to hear that" and then

continue the interview. It is important to emphasize that non-verbal behavior may be even more effective at expressing concern and respect for the mother's feelings than what the interviewer may actually say to the mother. Words are no substitute for sensitive, attentive listening particularly when the mother is discussing something distressing or of grave concern to her.

10. TRAINING

Training needs to occur both at the beginning and during the interview. One of the most common problems with training is that interviewers do not do enough of it, particularly with mothers who interrupt the interviewer. If a mother interrupts the interviewer more than twice while she is trying to read all of the response choices, the interviewer should train the mother by explaining the nature of the question. If this is not done, then sufficient training has not occurred and points should be deducted. In considering how to score this category, think of whether of the interviewer has made the mother's job as easy as possible.

11. PACE

This issue has not presented much of a problem for interviewers but a few things are worth keeping note of when scoring this category. First, make sure that interviewers are not speeding up as they read the response options. Second, make sure that even if the mother seems to be understanding everything, that the interviewer's pace is not too fast. Often, mothers want to rush through the interview because they have a time constraint and the interviewer speeds up to try to accommodate the mother. Instead of compromising the reliability and validity of the interview by reading the questions too quickly, the interviewer should tell mothers in this circumstance that they will try to complete as much of the interview as possible but that it might be necessary to either call her or visit her again.

Chapter 15

Section 2

MANUAL FOR THE FIFTEEN-MONTH HOME INVENTORY

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Chapter 15

Section 2

MANUAL FOR THE FIFTEEN-MONTH HOME INVENTORY

I. OVERVIEW

The information needed to score the HOME Inventory is obtained by having a Visitor go into the child's home and observe the mother interacting with the child and, in addition, interviewing the mother for information pertaining to other significant aspects of the family's interpersonal and physical environment. The general instructions given here are gender-biased, as it is assumed that most Visitors will be women. Care should be taken to ensure that the mother will not feel in any way "on trial." The interview should follow the tenets of all good human service interviewing and should be relaxed, non-judgmental, and friendly in tone.

In this manual suggestions are given for dealing with problems which occasionally arise in administration of the Inventories: restless or seemingly hostile parents, apparent dissembling, need for the parent to talk about other problems, presence of other children, etc. These suggestions have been based on users' experience and have profited from input offered by many persons in the field who have used the HOME over the past 20 years.

Scoring of the Inventories is always binary and has been

developed so as to maximize validity, simplicity, and feasibility. It is done quickly on the spot, and no clinical interpretation is required after the visit.

II. BASIC CONCEPTS

The acronym chosen for our Inventory--HOME (Home Observation or Measurement of the Environment)--effectively expresses many of the major concepts underlying its development and represents some of the skills that will be needed by any person who uses it:

A. Home

The data to be gathered are collected in the child's home, not in an office or laboratory. The HOME endorses a reaching out philosophy which communicates to the family, "This time I have come to you; you do not need to come to me." It also subscribes to the philosophy that you can truly appreciate a child's behavior and development only if you have experienced the child's most intimate and powerful environment first-hand. A home visit provides a richness of detail and a complexity of interchange that no interview can fully reveal.

B. Observation

Scoring for many of the items is based on what is observed during the visit, so obviously the HOME Visitor must be a good observer. Most of us think we are good observers, but often come away from a conversation with another person unable to report the

color of that person's eyes or hair. Some concentrate so effectively on small details that aspects of the background are totally lost. One thing training in the use of HOME will do is help the user become a better observer of some of the small transactions between children and their parents. Moreover, persons who are good observers have a head start in becoming proficient users of the instrument.

C. Measurement

The HOME is not just an informal data gathering process; it is a systematic measurement of the family environment. The measurement philosophy of HOME recognizes that skilled observation alone is not enough to allow a procedure to be useful for research purposes--or even for some clinical or educative purposes where precision of information is essential. Always there remains the onerous task of somehow converting the observations into quantifiable units. In the HOME we have used the simplest possible measurement system (counting) and the simplest type of item (binary). By observing whether certain events occur (parent praises child) and, if so, how often (at least twice), and then simply counting up the total of the designated behaviors, the amalgam of impressions and feelings is translated into a unified measurement system. For some clinical uses of the Inventory, one could stop short of this step; for research purposes, however, a commitment to measurement is necessary. When working with a family, one is sometimes tempted

to fall back on general impressions or feelings about the family. There is an urge to give "credit" to families we like or feel empathy for. Lost in this process is the value of careful, objective description--the kind of information that leads to fuller understanding.

D. Environment

Although the Visitor goes only to the child's home, in the process an effort is made to appraise the quality of the broader developmental environment. Certainly during the early years, home and family constitute the most important environment that exists for most children. However, information is obtained in the course of the visit which helps to give a picture of the milieu in which the child's home environment is embedded and the extent to which home experiences are strengthened by outside contacts likely to be meaningful to the child (e.g., trips with family members to grocery store, visits with relatives).

These four components--actual visits to the home, a preference for observation as a means of obtaining information, a commitment to measurement, and a recognition of the importance for development of the environment--represent the major vectors of the philosophy which guided the development of the instrument.

III. THE HUMAN SERVICE INTERVIEW

One important aspect of the procedure which is not covered by the acronym HOME is the interview that is necessary to obtain information to score some of the items. On the Infant-Toddler form of the Inventory, approximately one-third of the items will require supplementary interview data (although sometimes the visitor will have to ask questions about some of the toys, all of which may not be visible during the visit). Thus, an essential skill for persons who will use the HOME is good interviewing technique.

Much has been written about interviewing in human services, and anyone without training and experience in interviewing should begin by reading some of the widely used materials (Garrett, 1958; Shulman, 1978). Of particular help would be a document such as the Interviewer's Manual published by the Survey Research Center of the University of Michigan (1969). The anonymous authors of this widely used manual remind us that interview respondents must (a) find an interview pleasant and satisfying, (b) consider it important and worthwhile, and (c) not regard it as something to be feared or that might result in personal harm (e.g., a damaging report to the Welfare Department). Although these precautions were written with survey research in mind, users of the HOME can profit from them.

Although the interview is an important part of the HOME Inventory procedure, it is not the only part. Accordingly, we do not refer to the people who make the visits as interviewers;

rather, we have called them Visitors. In order to remain consistent with our acronym we might have called them observers, as observation is a crucial part of their task. However, that term seemed to us both a little intrusive and a bit pretentious. Thus we have settled on a term that aptly describes what we hope will be the tone of the HOME assessment--a friendly person visiting in the home, talking to a mother about her child.

In our experience it is rarely difficult to convince parents that this kind of visit is worthwhile. The talented Visitors who have worked with us have typically made the experience so pleasant that only rarely has any sort of suspiciousness or unpleasantness developed in relation to a visit. In fact, it is not unusual to have a mother come up to one of us at a public meeting and say something like, "Does Mrs. X still work with you? I used to love it when she came to see me when Y was a baby and we talked about things I did and toys I had bought." Such chance encounters offer evidence that our procedure is generally a pleasant and memorable one. Perhaps the greatest evidence of the comfort that most families feel is that over 99% agree to a second visit.

In spite of the impressive amount of informal evidence we have that a HOME visit is a pleasant and even cherished experience for many mothers, some professionals--almost always in advance of actually trying it out--seem to consider it an aversive procedure. They say things to us like, "People don't like to have anyone coming into their homes, snooping around to

see how they raise their kids." Our recommendation is that anyone who feels that way should not use the procedure. It is quite likely that such feelings will be communicated to the parent and distort what should be a personally satisfying and professionally helpful procedure.

IV. ASSUMPTIONS ABOUT EFFECTS OF THE VISITOR'S PRESENCE

The Inventory is administered by having the Visitor go into the home at a time when the child is awake and engaged in a reasonably representative routine for that time of day. No assumption is made that the presence of the Visitor in the home will not in some way distort the parent-child interaction. Furthermore, no assumption is made that the degree of distortion will be constant from one home to the next. However, it is assumed that with an increase in the time that the parent and the Visitor are together, it will become progressively more difficult for the parent to inhibit ordinary reaction tendencies.

Furthermore, the Inventory contains many non-interactive items, the scoring of which is less dependent on what the parent does or says during the time of the visit than on conditions that preceded and will presumably follow the visit.

V. GENERAL INSTRUCTIONS FOR ADMINISTRATION OF THE HOME

The scoring of the HOME will be based upon everything that is observed during the home visit, from entering the house until leaving, with the exception of the structured videotaping. The

videotaping will be omitted from consideration because it requires that the mother focus her attention on the baby and interact in specific ways. This scenario could be very different from the way in which the mother might respond to her baby during the normally structured HOME, thereby altering the score.

If the home visit cannot be completed in a single day, the following guidelines should be used for purposes of scoring the observation items on the HOME Inventory: a) if the visit on Day 1 lasts at least 1 1/2 hours and the child is present and awake at least one hour of that time, use only the observations made on Day 1; b) if the visit on Day 1 lasts less than 1 1/2 hours, use the observations made during the first hour of the visit on Day 2 together with observations made during Day 1 so long as the child has been present and awake for at least an hour during the course of the two days. Otherwise continue observations on Day 2 until the child has been present and awake for at least 1 hour total on the two days.

As already indicated, HOME items are sometimes based on information supplied by the parent and sometimes on direct observation of what transpires during the visit. Sometimes with older children, the information actually comes from the child. The Visitor will be observing and interviewing at the same time, but the instructions can be simplified if these two aspects of the procedure are separated for discussion.

A. The Interview

To score these items which require information that cannot be obtained by observation (e.g., whether child is taken to grocery store) we do not recommend a standard interview for eliciting the needed information. We do, however, recommend one standard feature--good interviewers. A good interviewer is a person who can be at ease in the situation, can put the mother at ease, can easily adjust subsequent questions to responses of the mother, and can ask questions in such a way as to avoid putting the parent on the defensive and thereby causing the parent to second-guess the Visitor as to what is the "right" or "expected" response. The Visitor's goal is to be objective and accepting as opposed to approving or disapproving. This is essential if she is to find out how the parent feels and what the parent does with her child rather than what the parent thinks the Visitor wants her to say.

Before actually trying to conduct an interview, it is important to be completely familiar with the items. This will help the Visitor be more relaxed and will help the person with whom she is talking feel less "on stage." (see later section on Training).

B. General style

Obviously the Visitor must be careful not to ask questions in a threatening or judgmental manner. For example, rather than ask, *"Do you ever read stories to your child?"* it is preferable to ask, *"Do you ever manage to find time to sit down and read to*

her?" If the mother answers affirmatively, the Visitor can explore further by inquiring, *"How often does he like you to do that?"* You will note here that the burden of frequency is put on the child, not the parent; however, in her answer she will inevitably describe her own behavior, e.g., *"He would like me to sit and read to him all day, but I can't do that. I tell him, 'I've already read to you, and one book a day is enough!'"*

Although it is a good idea to develop techniques for avoiding seemingly accusatory questions, the Visitor should not be so concerned about subtle wording as to ask the question in a way that will elicit tangential and irrelevant answers to the items as worded. Reassurance for timid Visitors should be found in the fact that most mothers believe that what they do with and to their children is for the children's own good, and they often report with pride actions that you might expect them to try and conceal.

C. Starting the HOME

A good technique for beginning the interview, and for helping the mother to relax, is to ask her to describe a typical day in the home, using something like the following statement:

"You will remember that we are interested in knowing the kinds of things CHILD does when she is at home. A good way to get a picture of what her days are like is to have you think of one particular day--like yesterday--and tell me everything that happened to her as well as you can remember

it. Start with the things that happened when she first woke up. It is usually easy to remember the main events once you get started."

If the mother cannot get started, help her with questions like, *"Was she the first one to wake up?"* The Visitor should jot down notes during the interview. If the parent asks why the Visitor is taking notes, reassure the parent that it is being done *"to help my memory"* or *"to keep me from losing track."* Most parents run through the recital of a day's events in about five minutes. Although this procedure is designed more to warm up the mother than to provide specific information, she may in the course of her narration supply spontaneously the information needed to score several items, e.g., *"We went over to my mother's and I had to whip him twice for getting into her cabinets."*

Please note that for the purposes of the common protocol this method of initiating the HOME procedure will be required. Keep in mind that its purpose is to set the stage for a comfortable interchange: one which is not artificial, ritualized, or like a teacher asking students a series of questions.

D. Areas Covered in the Interview

Much of the information necessary to score the Infant-Toddler form can be obtained with only four broad probes. These deal with (1) trips out of the home and visits into the home, (2) toys and learning materials that are available to the

child, (3) the daily family routines, and (4) training and discipline.

In the event the interview has occurred in a part of the apartment or house (perhaps the kitchen) that does not allow the Visitor to see the other parts of the living quarters, a few miscellaneous questions will permit the remaining information needed to score the Inventory to be obtained (like whether the child has three books or whether the total living environment is safe from hazards). Seeing other major parts of the house (such as the child's room) is desirable, though not necessary. However, the Visitor must exercise sensitivity in determining whether to ask the parent to see other rooms in the house or apartment if the mother does not volunteer a tour.

Most of the information necessary to score the Inventory will flow forth fairly smoothly without the use of precisely worded probes. It is better to get the information as the parent provides it rather than through the use of an invariant interview procedure. However, it is important to check each item before leaving the home. It is very easy to think that you have obtained all the necessary information, when actually you omitted some items. The single most common mistake made in using the HOME is that the Visitor does not get enough information to score all the items. In some cases, it may be advisable to call the mother's attention to your checking of the items rather than wait for her make an inquiry about it (see page 10.) A simple statement such as, *"I'm jotting this down because if I don't, I*

may forget some of the things you tell me," will usually handle the situation nicely. Parents know you are there to learn about the child, so they are rarely concerned that you take notes or check your information before leaving.

E. When to complete coding

It is advisable to complete the coding of the Inventory before leaving the house; do not trust your memory. If possible the Visitor should complete the HOME form while the mother fills out her questionnaires.

While the mother is filling out the 15-month questionnaires, make certain that all areas requiring a score have been covered. This time will also give the Visitor an opportunity to be a close observer during a period when she does not have to worry about what question is to be asked next. During this time the Visitor should also check all items that are based on observation only. Before leaving the home, the Visitor should have placed either a plus or minus mark along side the number of every item on the Inventory. Soon after leaving the home the scan box should be filled in for only those items which received a plus.

F. Exceptions to Standard Procedures

Whenever one tries to define standard conditions under which procedures should be carried out, one immediately has to face the inevitability of more exceptions than standards. Such has certainly been the fate of the HOME. In designing the instrument

we opted for binary (either-or) choices rather than ratings along a continuum, for arbitrarily selected cutting points ("...no more than one instance of physical punishment occurred during the past week") rather than estimates of quantity and severity ("...uses physical punishment extensively, moderately, minimally"). We hoped thereby to eliminate a great deal of the subjectivity ordinarily associated with similar inventories. Accordingly, with each revision the items became more and more concrete and, we hoped, objective. However, significant objectivity for one family reads "does not compute" for another.

For example, many of the items begin "Parent does..." something or other (reads to child, encourages developmental advance, provides toys, etc.). As discussed earlier, this choice of wording reflects the orientation that the parent--most typically the mother--is indeed an important person in the life of the young child and will be the major interpersonal influence on the child's development. Of course, this does not mean that the parent will supply all the care provided the child. For example, in homes with older siblings, many of the activities covered by Inventory items might occur in the life of the child but might be provided by an older brother or sister. Some mothers have responded to items such as "Parent reads stories at least three times weekly," with a statement such as, "I don't, but the older kids do."

The frequency with which such exceptions occur requires the articulation of an overriding principle which will help the user

make decisions about the scoring of individual items. The intent of the assessment procedure is to get a picture of what the child's world is like from his or her perspective--i.e., from where the child lies or sits or stands or moves about and sees, hears, smells, feels, and tastes that world. If that principle is kept in mind, then the Visitor will not have to split hairs to score some of the items. The Inventory is attempting to assess the home environment from the perspective of the child and is not exclusively appraising the caregiving abilities of the mother. Toys bought for an older child but made available to the key child can still help in the acquisition of eye-hand coordination. Books read by an older child still foster language acquisition. In order to obtain an accurate picture of the home environment, it is critical that we learn a great deal about the input supplied by the parent(s). However, a still broader portrait of the supportive qualities of the home can be obtained by evaluating each exception in terms of the simple question: What is in it for the child?

While the scoring of items on the HOME should always be done from the perspective of the child, the NICHD Study of Early Child Care imposes some constraints on the home visit that are not typically present when the HOME alone is the focus of a home visit. For example, the NICHD visit is being conducted so that the focus is on the mother rather than on the full array of caregivers, family members, or other household residents that may typically be present in the child's home environment. To the

greatest extent possible, the NICHD visit is being conducted in such a way as to reduce (and, hopefully eliminate) input, including simple distractions, from other household members. These constraints, as important as they are for the purposes of the study, are likely to lead to some "non-normal" behavior on the part of other household members. For this reason, the decision was made to score those items requiring direct observation of parental behavior in a manner different from what would ordinarily be done with the HOME. Specifically, the items will be scored exclusively on the basis of the mother's behavior during the visit. The items affected are: #1, #2, #3, #4, #5, #6, #8, #9, #10, #11, #12, #13, #14, #16, #17, #29, and #35. To reiterate, when scoring these items, score them exclusively on the basis of the mother's behavior. Do not count the behavior of other household members when scoring the items. This decision rule applies only to those items. For instance, if during the course of the interview you find out that the mother does not read to the child at least three times weekly (Item #42) but the father does, the item should still be scored at "YES". The same would also be true for Items #36-#40, #15, etc. (i.e., all the items that do not require direct observation of behavior during the actual home visit).

G. The Observations

Throughout the session, the Visitor will be observing the behaviors of the caregiver and those aspects of the physical

environment which comprise Inventory items. However, it is not a good idea to wait until the interview is completed to try and make a decision as to whether the behavior has actually occurred. Familiarity with the items and with the level or quantity of behavior chosen to designate success (e.g., kisses child once, verbalizes twice, etc.) leads to a general alerting on the part of the Visitor to such behaviors as they occur. A notation should be made on the Inventory form as quickly as possible. The recommended review of the Record Sheet at the end of the interview provides an opportunity to make certain that you have indeed paid careful attention to the kinds of behavior referred to in the observation items. The Visitor may have forgotten to praise the child in order to note the parent's response. If so, a quick check of the Record Sheet will serve as a reminder to set up the situation so that the parent's response can be observed.

Some people who use the Inventory have reported that they feel frustrated in making their observations for the interpersonal items because the really outstanding parent--the mother who verbalizes to the child 20 times during the visit rather than twice, the one who glows rather than smiles when the child is praised--does not receive a higher score than the one who is barely above the cutting point. In defense of this perceived weakness of the instrument, we offer a reminder of the major reason behind the development of the Inventory--the identification of at-risk environments where both the children and the parents could benefit from carefully planned

intervention. The videotaped observational procedures in the 15-month home visit are designed to assess more finely the qualities of mother-child interaction, so this information will not be lost.

One final word should be said about reliance on observation versus interview for the items relating to play and learning materials in all versions. It was originally intended that these be observational rather than interview items. In most cases, this is how the items are scored. However, the visit usually takes place in the living area of the home or apartment, and frequently toys are not stored in this area. As long as the child is present during the session (which is de rigueur), certainly some toys will be brought in for the occasion. Furthermore, they will most likely be the ones which the parent feels are "good for the child" and will be the very ones the Visitor will need to observe. However, it is acceptable to ask about other categories rather than demand to see the objects. If for any reason the Visitor feels that the parent is not clear on the type of toy asked about but says that she has bought one for the child, the Visitor might ask her to get it and let the child show how he or she uses it. She could say something like, "I'd love to see it. Do you mind getting it and showing it to me?" This can easily be handled with good taste in such a way as to cause no discomfort to either the parent or the Visitor.

H. Debriefing

The HOME is one of several procedures in the Fifteen Month Home Visit. Keeping in mind that there will be an additional interview and questionnaires given in this same visit, we would recommend that a significant time for debriefing or wrap-up comments not be taken following each procedure but be concentrated at the end of the visit. However, it is important to make certain that the parent has not in any way been upset by the HOME interview. Therefore, a few pleasantries or general questions as well as the introduction of the next portion of the visit should be used and will serve as a debriefing opportunity for each procedure.

When all HOME items requiring interviewing have been covered, make the transition to the videotaped observation by saying something like the following:

"That's all I need to ask you about for now, but we'll have an opportunity to talk some more about BABY's experiences a little later on in my visit. This looks like it will be a good time to set up the videocamera to film BABY."

VI. INDIVIDUAL ITEM INSTRUCTIONS

For the experienced user of the HOME, the wording of the items on the Record Form will stand alone. However, until a potential user is completely familiar with the procedure, some amplification of precisely what is intended by each item is necessary. Such amplification for all items on the Infant-Toddler HOME is provided in this chapter. Because of

their simplicity and binarity, the items are about as unambiguous as any scale developer can hope to achieve. However, language being what it is, some residual ambiguity is inevitably present in any abbreviated description of complex interactions or events. Accordingly, we have attempted to clarify precisely what is meant by each item in order to enhance reliable use of the Inventory.

As the Infant-Toddler HOME was the first version of the Inventory developed and standardized, it has also probably been more extensively used than any other version. Accordingly, over the years we have had the benefit of questions and suggestions from countless distal colleagues as to ways of amplifying the item descriptions in order to achieve maximum clarity and minimal ambiguity. In the material to follow, we have assimilated these suggestions into our own in hopes of facilitating ease and reliability of use of the Infant-Toddler HOME. The items are discussed within their subscales in the order in which they appear on the Record Form.

A. Responsivity

This factor is defined as describing the extent to which the parent responds to the child's behavior, offering verbal, tactile, and emotional reinforcement for desired behavior and communicating freely through words and actions. Some of the items which loaded on this factor are based on responsivity of the parent to the Visitor rather than directly to the child. Obviously such items are based on the assumption that the

parent's style of responding to the Visitor will reflect habitual patterns of social response and will therefore predict interaction modes between parent and child.

1. Parent spontaneously vocalizes to child at least twice.

"Vocalizes" refers to any sound or words emitted by the parent except scolding or chastising. For example, she may say, "S-s-s" or "Sweet baby," or any random words or sounds. In order for this item to be scored positively, the mother's vocalizations must have occurred spontaneously as opposed to having occurred in response to some vocalization by the child. If the mother scolds or derogates the child repeatedly (i.e., far more than twice) but does not otherwise converse with him or her, this item should be scored negatively.

2. Parent responds verbally to child's vocalizations or verbalizations.

Again the parental response may be either a complete word or words or merely clearly differentiated sounds, e.g., "ta-ta"; "tsk-tsk," or "You talking to Mommy?" The key factor here is that the parent is responding to the child's vocalization, not ignoring it. If the child does not vocalize during the interview, thereby denying the mother an opportunity to respond, the score would still be "No."

3. Parent tells child name of object or person during the

visit.

The mother does not have to say, "That's an apple," or "We call this a purse," in order to obtain credit on this item. What is being measured here is the adult's sensitivity to the child's search for labels of objects around him. Credit for this item may be earned by a pattern of emphasis with the voice. For example, "Do you remember Miss Jones?" referring to the Visitor. She has "taught" the word with her intonation and supplied a referent for the child.

4. Parent's speech is distinct, clear, and audible.

A positive score on this item is determined by whether the Visitor is able to understand what the mother says. This item should not be interpreted as meaning that dialect usage mandates a negative score. What is important is whether the Visitor can understand and communicate with the mother.

5. Parent initiates verbal interchanges with Visitor.

In order to be credited on this item the mother must demonstrate some initiative in asking two or three questions or making spontaneous comments that go beyond the bare minimum needed to give an answer. It is not necessary that she do this on all questions; however, occasionally she should take the initiative in the conversation and be a little wordy.

6. Parent converses freely and easily.

In order to receive credit on this item, spontaneity is not as important as fluency. That is, the mother will be talking about things that are very close to her, and it should be very easy for her to express her ideas on this subject. A "No" would be given to a person who tends to speak in one word sentences or to use headshakes. An occasional exception would not earn credit; the characteristic speech pattern should be noted.

7. Parent permits child to engage in "messy" play.

This item was developed as one that should cluster with others in the general category of acceptance. However, it had a higher loading on this Responsivity factor and has accordingly been placed here. Certainly the parent who manages to allow a little messy play without getting too upset is responding emotionally in an appropriate manner. To be given credit, a mother does not have to disavow concern with wanting to see such behavior disappear from the child's repertoire; she must merely be willing to tolerate it occasionally. Included may be such things as playing with sand, mud, water, fingerpaints, or, for young babies, food.

8. Parent spontaneously praises child at least twice.

In scoring this item, do not hesitate to read the parent's

affect--any achievement reported with pride should count (can dress himself, has a good disposition, etc.). However, occasionally a mother will indicate approval of her child's behavior by making what appears to be a negative statement--"I tell you, this kid is really bad." If she says that with a smile on her face and immediately follows the statement with some rather remarkable achievement--"Would you believe he climbed out of his crib, got his bottle, and climbed back in all by himself?"--from which one can obviously infer that she is proud of him, then consider this one instance of praise. Do not credit this kind of semantic reversal if it stops with the negative term; score only if some proof of positive feeling is offered, and only if the compliment is spontaneous.

9. Parent's voice conveys positive feelings toward child. What you are looking for here is evidence that the parent feels good about her child--sounds animated when speaking about him or her, does not use a flat or querulous tone of voice, etc. Generally the comments will be accompanied by positive facial expressions.

10. Parent caresses or kisses child at least once. Under "caresses" would be included a hug, a stroke of the hair, patting an arm or leg, reaching out affectionately and touching the face, etc. Blowing a kiss as well as actually

establishing physical contact may be counted as a kiss.
Simply touching a child does not constitute a caress.

11. Parent responds positively to praise of child offered by Visitor.

In order for the parent to earn credit on this item, the Visitor must remember to offer some praise of the child. Make certain that your praise is genuine--i.e., do not try to force praise that you do not feel as you look at the child. Usually you will have no trouble deciding how to score this, as a parent might agree with you, add more facts to encourage you further, beam, etc. However, sometimes you will get little more than a "Thank you" said without feeling or an embarrassed smile; however, be careful not to overdo it (i.e., more than three times) so as to "force" a reaction. If so, find more than one occasion to praise the child. If you consistently get a response that shows no feeling or pleasure, then score negatively. Be alert to observe the parent's facial expression when you praise the child.

B. Acceptance

This factor covers parental acceptance of less than optimal behavior from the child and the avoidance of undue restriction and punishment.

12. Parent does not shout at child.

A positive score on this item requires that the parent not raise her voice to a level above that required by the distance between her and the child.

13. Parent does not express overt annoyance with or hostility to child.

A mother would receive a minus score on this item if she complains that the child is hard to take care of, that he is wearing her out, if she calls him "bad" without the affectionate joke described above, says he will not mind, and so on. Examples that would fail to receive credit would be remarks such as, "I don't know what I'm going to do with this kid," or "This kid is driving me up the wall." A mother might tell a child to stop doing something several times during the interview and still be credited for this item if her general tone is positive.

14. Parent neither slaps nor spansks child during visit. Occasionally a visitor will feel that she does not know whether a mother is playing with or seriously slapping or spanking a child. The best guide to use in such instances is the child's behavior. If the child reacts with pleasure or happiness, chances are this represents a style of positive interaction between her and her mother. If she frowns or looks unhappy or whimpers or cries, you can feel

pretty confident that, however the mother intended it, she does not perceive it as pleasurable. Score "minus" accordingly.

15. No more than one instance of physical punishment during past week.

Most parents define physical punishment as spanking; some apparently seem to regard it as true punishment only if something other than the hand has been used. Some parents regard restraint and shaking a child also as involving physical punishment. Our definition includes all of the above, even if the parent has a different idea (i.e., doesn't count unless a paddle or belt is used). If the child is hit, shaken, pushed against a wall or object, paddled, or just poked hard with a finger, score as physical punishment.

16. Parent does not scold or criticize child during visit. This item is obviously similar to #13 above. However, the main difference is that on this item the parent must make the negative remark directly toward the child. That is, "You are a bad girl," not "She (speaking to Visitor) is a bad girl." If such a remark occurs one or more times, score "-"; otherwise score "+."

17. Parent does not interfere with or restrict child more

than three times during visit.

Restrictions and interference here refer to such things as: taking a toy away from a child; putting a child who has climbed up on the sofa back down on the floor; putting a child who is crawling around the floor into a playpen or crib; slapping a child as he starts to pick up the Visitor's handbag. In the last instance, the item would be applicable to both items #17 and #14. The restrictions may also be verbal--"Stop that"; "Get out of there." Do not code as interference any action taken to prevent the child from harming herself (e.g., running into the street).

18. At least ten books are present and visible.

This item, and the one to follow, appear less faithful to the intent of the Acceptance factor than the others. Yet a post hoc explanation is always possible. Having books when there is a toddler present always poses a slight risk of having them torn or damaged, so their presence and availability identifies at least a willingness to cope with the child's curiosity and exploratory behavior--a clear form of acceptance. The same can be said for having a pet. A manipulable pet in the household of a toddler runs a definite risk! Parents who allow this are clearly being accepting of immature behavior. The word "visible" was added to this item to make it an observation and not an interview item. However, being able to observe whether

there are books present in the home might require a request to go through the entire house or apartment without a spontaneous invitation to do so from the parent. In such instances, do not hesitate to ask about the books that the family has. The item will help indicate whether the child is growing up in a reading family, or in a family that values having books around. For example, there might be a set of encyclopedia on the shelf that have obviously not been read. Even so, credit would be given for the item, as the presence of the books indicates that the family values them. It is important to note that this item does not refer to children's books. Children's books are dealt with in Item #45. It is also important to remember that the books should be located in the home in a place where the child can see them. If the only books a family has are kept in a box on a closet shelf and rarely brought down, they are not available to the child.

19. Family has a pet.

It seemed incredible that this item could have any content ambiguity, but apparently some Visitors have had trouble deciding whether one or another type of animal that has temporary residence in the family can truly be called a pet. In our definition the word refers to an animal that the family takes care of and the child can play with or look at--i.e., one that stays in the home on a semi-permanent rather than a temporary basis (such as a dog, cat, bird,

turtle, goldfish, hamster, as opposed to a captured grasshopper, a lame bird, or a jar full of lightning bugs, etc.).

C. Organization

This factor refers to the extent to which there is regularity and predictability (without monotony) in the family's schedule, to the safety of the physical environment, and to the inclusion of community services as part of the family support system.

20. Child care, if used, is provided by one of 3 regular substitutes.

The intent of this item is to determine whether the child's social environment is reasonably predictable and stable. Thus if the mother says that, whenever she is away, she leaves her baby with her ten-year-old daughter, this would still be scored positively even though the Visitor might question the ten-year-old's ability to provide adequate care. Credit the father as a substitute on this item also (if he is regularly used). If a child is in an alternate-care setting with several caregivers, each person who provides care is counted. If child care is not used at all, which may rarely be the case, score positively.

21. Child is taken to grocery store at least once a week.

This item attempts to get at the breadth of experience that the young child has. A grocery store is a very stimulating environment, and any size store that a young child gets taken to should be credited. Do not worry about whether it is a supermarket or a tiny neighborhood hole-in-the-wall. Something other than a grocery store (such as a department store) does not count.

22. Child gets out of house at least four times a week. The infant/toddler may be taken no farther than the yard in order for credit to be given. The intent of the item is exposure to sounds and sights and objects and people other than those routinely available within the house or apartment.

23. Child is taken regularly to doctor's office or clinic. This item is intended both to assess the regularity and consistency of the environment and also whether the environment offers some of the necessary conditions for growth and development, such as check-ups and preventive health care. Scoring should be adjusted to the age of the child--i.e., approximately a every month up to about eight or nine months of age and once every six months to a year thereafter.

Do not be overly rigid in scoring this item. The "standards" for health care (i.e. recommended schedule of

visits) vary a little from place to place. If the standard established by the baby's doctor or clinic is one every two months during the first year of life, that is acceptable. However, it is unlikely that the recommended schedule of visits during the first 6-9 months of life is less than once every two months.

24. Child has a special place for toys and treasures. This item will reflect the predictability of the child's environment. The special place may be a closet, drawer, a plastic basket, or even a cardboard box or paper bag. It need not be a fancy chest especially sold for children's toys. It does not have to be in a special room. The accessibility of the special place for either removal or returning toys by the child is the essence of the item. The special place does not have to belong exclusively to the key child; it may be shared with another sibling.

25. Child's play environment is safe. The Visitor should use her own good judgment in scoring this item. Examples of hazards are: broken glass lying around, furniture with wood splinters or exposed nails or pins, an uncovered rotary fan, boards with nails sticking out, unprotected stairs for a pre-walking baby, house so close to the street that child could not safely play in the yard, pot handles extending over edge of the stove, etc. Overcrowding

or clutter would not count as a hazard unless it existed to the extent that it could injure the child.

D. Learning Materials

This factor deals with the provision of appropriate play and learning materials capable of stimulating development. The factor could have been called something like Toys and Equipment to Support Development. Historically, we did call it that and various other things at different times in the past. But in trying to shorten all the subscale labels, we settled on the true common denominator of the items included here--they are materials which, when used by the child, provide tools for the development and refinement of crucial skills which must be acquired during the infant/toddler years. Thus we have relabeled the subscale, Learning Materials.

In scoring items in this section, it is important to keep in mind the developmental function served by each type of play equipment mentioned. What is crucial is not whether the toys are shiny and new and expensive or whether they are home-made or hand-me-downs. What is important is whether they will allow the child to touch, feel, manipulate, move, listen, and have fun in the process! Also it is not critical that the parents were the ones who purchased the toy. What matters is its availability to the child.

For each of the items in this subscale, the child must have access to the toy or piece of equipment. If someone has

purchased the toy for another child in the family but the child who is the subject of the visit is prohibited from using it, then credit should not be given.

26. Muscle activity toys or equipment.

Examples are crib gym, ball, rocking horse, jumpseat, door swing, or walker. If such equipment had not been provided by the parent but is available in the apartment or housing project, the item should be credited so long as the infant or young child is granted access to it. Also the item need not be identified by the family as "belonging" to the child; it might be shared with siblings. However, it must be available for use. Thus, for all the toy items, credit would not be given if someone had bought the toy for the child but it had been lost, broken, or stolen. In such cases it would not be available.

27. Push or pull toy.

Examples are toy lawn mowers, vacuum or carpet sweepers, corn poppers, music boxes on a stick, xylophone that is pulled by a string, wagon, etc. Credit also a shoe box with a string attached, a real carpet sweeper (with which the child can regularly play), or a kitchen stool on wheels.

28. Stroller or walker, kiddie-car, scooter, or tricycle.

These items are all self-explanatory--anything with wheels

that a child can ride on or in, or a large wheel toy that the child can manipulate.

29. Parent provides toys for child to play with during visit.

In order to be credited on this item, the parent must make some special effort to see to it that the child has something interesting to do during the visit. If the visit is conducted in a room that contains a number of toys or the child's toy box, one should assume that the mother has taken special efforts to have something available to entertain the child during the interview. If, however, the child tires of what is available and begins to whimper or to ask for something to do, this item should not be scored positively unless at that time the parent makes some special effort to bring out a new toy or do something else to interest the child.

30. Cuddly toy or role-playing toys.

This is an item that has a certain amount of age flexibility. For children up to about 18 months, a teddy bear or other stuffed animal or doll would provide the tactile experience presumably offered by a cuddly toy. For children between roughly 18 months and three years, any kind of doll or stuffed animal that stimulates make-believe would be credited. It may occasionally be more difficult to

decide on this item when the key child is a boy, as families are often loathe to provide their boys with anything that is "sissy." In such cases a cowboy suit or policeman's or fireman's hat would be acceptable. Cowboy boots would not.

31. Learning facilitators--mobile, table and chair, high chair, play pen.

What is essential here is that the parent provide the child with a piece of equipment considered necessary for various types of learning to occur, not just with a toy. (Mobile was included in order to have something applicable to very young infants.) The play pen may seem out of place in this item. It was included because it provides a safe environment in which an infant can play when the parent cannot provide direct supervision. In order for a play pen to be used for a positive score on this item, the parent should indicate that toys are placed in it whenever the baby is there.

32. Simple eye-hand coordination toys.

This item involves such things as small objects that can be placed in and taken out of a receptacle, toys with more than one part that can easily fit together, large beads to string, etc. The objects should be fairly small and should require precise hand movements--the child should not be able to move around and manipulate them at the same time. To

count, the toy, by its nature, should require actual coordination of eye and hand. For a 15-month old, a rattle is not sufficient.

33. Complex eye-hand coordination toys.

Obviously this item is similar to the previous one, and Visitors will have to make an occasional judgment call as to whether a given coordination toy is "simple" or "complex." Both simple and complex manipulation toys often involve the combination of components. The key to the judgment of complexity is whether the combination that results from the child's manipulations can create an item that is more than and different from that created with repetitive combinations of similar identical components. Thus beads to be strung (resulting in more beads on the string if successfully manipulated) is a simple eye-hand toy. So, too, are toy bars, button/zipper/snap toys, snap beads, geometric shape sections, etc. Lego blocks (which can result in shapes totally different from the shapes of the individual pieces) would be a complex eye-hand toy. Other examples of complex coordination toys would be nuts and bolts, Lincoln Logs, Tinker Toys, Light Bright, Bristle Blocks, and transformers, etc. Another thing to consider in trying to make the distinction between simple and complex eye-hand coordination toys is what the object generally affords the child as a stimulus for action. Simple toys are those which primarily

give a child an opportunity to engage in repetitive motor actions. They require eye-hand coordination to accomplish but not much else. The complex object also has the potential to elicit combinations of the parts which result in something different from the individual pieces. They do more to encourage problem-solving, planful, and even creative behavior to execute the combinations. In scoring this item, the Visitor must remember that what is crucial is not whether the infant/toddler uses a potentially complex toy in a mature fashion (e.g., tries to make a house with Legos) or uses it only in a somewhat pedestrian fashion (e.g., makes a "road" out of bricks all the same size). What is being measured is what the parents have provided, not what the child can do.

34. Toys for literature and music.

This includes tapes, books, records, toy musical instruments, etc. Although the "literature" part (books, talking records) of this item seldom causes any trouble, the "music" part does. A record player that the child may manipulate would be a perfect example in that both story records and music records could be played on the instrument. Again consider the age of the child in scoring this item. For example, a rattle with a musical jingle would be acceptable for a baby but not for a toddler. The radio is acceptable if the child is allowed to turn it on and select

a station. The same would be true for a record player that belongs to the entire family. If the family record player is accepted, then the child must be permitted to manipulate it. At least two such toys must be available (one for literature and one for music) in order for credit to be given on this item. Throughout items #30 - #34, the key to scoring is that the child be allowed to manipulate the play item even though he/she may not choose to do so. For example, the parent may report that she has bought books for her child but that the child never plays with them. In such instances, inquire in order to determine whether this is because the child is not interested or whether they have been kept from him or her. "Provides" requires that the child is not forbidden to touch, handle or play with the item. The parent does not have to be the one who bought the items. What is critical is that the items be available to the child.

E. Involvement

This factor defines the extent to which the parent is actively involved in the child's learning and provides stimulation for increasingly mature behavior.

35. Parent keeps child in visual range, looks at often.
"Often" means frequently enough to ensure safety of the child and to keep some kind of interpersonal contact

going--the sort of thing lovers do when in the same room but out of reach of one another.

36. Parent "talks" to child while doing household work.

"Talking" to the child in this item means that the parent in the course of her or his own work activities finds a way of including the child in what is going on. The parent may talk directly to the child, e.g., "Well, Mommy's going to wash these dishes now"; or "It's time for me to go to work." Perhaps the mother may simply talk as though to the child as she goes about her work, "I don't see how one family can get a house so dirty." The critical thing is that these comments occur within hearing range of the child or possibly with direct eye contact.

37. Parent consciously encourages developmental advance.

The first key word in this item is "consciously," as it is indicative of a teaching attitude on the part of the parent. The second key word is "encourages." In order to encourage, the parent must do more than just "allow" the child to develop or a particular type of behavior to occur. Instead, the parent must take an active role (e.g., arrange the circumstances to assist development, praise the child's efforts, provide specific opportunities for behavior to be rehearsed). Credit on this item is given to the parent who finds little ways to help the child learn to roll over, who

occasionally puts a toy out of reach to encourage crawling, who gives the child a spoon to let her try to feed herself, who tries to teach patty-cake, etc.

38. Parent invests maturing toys with value via personal attention.

Maturing toys are those which, the first time the child is introduced to them, call for abilities a little bit beyond any demonstrated to date. Thus they involve the acquisition of new skills and offer the child a challenge. Many times parents will buy such toys, put them down in front of the child, and assume that the child should go on alone from there. Success on this item requires that the parent "talk up" the new toy, sit down and play with it herself or himself with pleasure and glee, or show the child how it can be used and encourage play with it. The encouragement should be participatory, not via some command like "Go play with the fancy blocks I bought you."

39. Parent structures child's play periods.

This does not mean that the parent must decide everything that the child should do throughout the day. Rather it refers to one who recognizes the short attention span of the young child and the need to offer occasional suggestions as to things the child might do. Structuring need not involve any request that the child play. For example, the mother

who notices that her child is fretful, who then goes and gets a corn popper and puts it down in front of the child is structuring the play period. Credit should also be given for a more verbal parent--i.e., one who says, "Why don't you go and get your corn popper and play with it." Parents do not receive credit who merely provide some time during the day for a child to play. They receive credit when they actually provide structure for the child's play activity (e.g., arranging play objects, providing directions, cueing and responding to child's behavior during play, etc.)

40. Parent provides toys that challenge child to develop new skills.

Scoring this item requires some awareness on the part of the Visitor of toys that are and are not appropriate for children of a given age level. What is being assessed here is the caregiver's skill at estimating the child's ability and interest level and at finding materials that will challenge further development. Credit should be given even if the parent appears to overestimate the skills that the baby is ready to begin to acquire.

F. Variety

This factor encompasses the inclusion in daily life of people and events which bring some variety (without disorganization) into the child's life.

41. Father provides some care daily.

If there is no father or father figure in the home, score "minus" for this item. However, the "father" does not necessarily have to be a husband of the mother or even a biological father of the child. He must, however, be someone who plays a fathering role--e.g., mother's boyfriend, mother's father, etc. For credit to be given, father does not have to live in the home 24 hours a day but must have some daily contact with the infant/toddler.

42. Parent reads stories to child at least three times weekly.

This should refer to a children's book or magazine and, except with young infants, should be more than merely turning pages of a magazine and saying words. If the parent says, "I don't, but my husband or the older children, grandmother or the live in caregiver do," score "+" if the designated reader is old enough to be a true reader. Give credit for this item if anyone who resides in the home reads to the child.

43. Child eats at least one meal a day with mother and father.

This may be any meal, and the child may either be fed or placed in high chair at table. She may be fed in a feeding table provided it is pulled right up to the table and the

child is conversationally included at the table. In one-parent families with no person who either is the father or who plays the fathering role, this receives an automatic "No."

44. Family visits relatives or receives visits once a month or so.

The relatives referred to in this item need not be from the immediate family (grandparents, aunts or uncles). They need not even be blood relatives. However, they must be someone regarded by the parent as "family."

45. Child has three or more books on his/her own.

The books may be shared with sibling, but they should be accessible to the index child most of the time. The books may have formerly belonged to an older sibling, but the index child should now see the books as being available to him/her more or less whenever they are wanted. The books do not have to be the exclusive property of the index child. Credit should be given so long as the books are readily accessible to the child and so long as the child does not think of the books as being the primary property of a sibling.

VII. SPECIFIC INSTRUCTIONS FOR ADMINISTERING INDIVIDUAL ITEMS

As stated earlier, we recommend flexibility in observing and

interviewing during the home visit in order to obtain valid information about the child's current home environment. Real homes are alive and dynamic, and most parents are spontaneous and animated when they talk about their children. In such instances you will get a better picture of the environment if you allow the parent to lead, accommodating information they provide to the wording of your items, and probe only when necessary. With other parents, of course, getting information is like pulling teeth. In such instances, you will need to check your interview prompts, note (if you have not already memorized it) the exact wording of the items, and make certain that you get all the needed information. Even in such homes, flexibility and informality on the part of the Visitor are needed to avoid an atmosphere which seems intrusive, formal, and too businesslike.

A. Observation Items

With the exception of Items #7 and #15, the first 18 items on the Infant/Toddler HOME are based entirely upon observation. Items #7, #15, #20-23, #35-39, and #41-45 depend largely on the interview. Items #19, #24, #26-34, and #45 can go either way. That is, observation may yield all the information necessary for scoring. However, if not, it is probably better to get the necessary information by interview on these items than to have the Visitor request to see a part of the house other than the area which the mother has set up for the visit. Item 40 is technically neither observational nor interview-dependent. It

requires a judgement call based on what is seen and learned during the visit.

Even though the first third of the Infant/Toddler HOME is based almost exclusively on observation, the Visitor should not expect to make the observations within the first third of the visit. In fact, none of the items can really be scored until the very end in that they pertain to behavior that might occur at any time during the visit or else to a specified number of occurrences over the entire observation period (e.g., praises child at least twice).

Essentially what you are observing is the nature of the interaction between the parent and the child. Even though the items are binary and sound very cut and dried, they manage to communicate the tone of the interaction: Is it warm and loving or distant and possibly hostile? Is there mutual pleasure in the relationship or annoyance and frustration? Are the needs of the child recognized and accepted, or are things run primarily on the parent's terms? These subtle manifestations of the nature of the home environment will indeed show up in the observation items.

Knowing the items in advance of the visit and being familiar with the exact cutting points chosen for the binary items (e.g., once, twice) will help the Visitor remain alert throughout the visit for the requisite number of occurrences. During the wrap-up moments of the visit it is crucial to check and record in case you need to "stage" something you might have forgotten (e.g., praising the child to note the mother's response) in order

to be able to score all the observation items.

B. Interview Items

As suggested in Chapter 7, the information necessary to score all items based on the interview can be derived from asking questions covering roughly four areas of family life: (1) outside trips, (2) available toys and learning materials, (3) family routines, and (4) training and discipline.

In the exposition to follow, all examples use "mother" as the referent rather than "parent," as in the case on the Record Form. Although this may seem inconsistent with our decision to use the word "parent," we can offer an explanation. In the suggested interview probes, we have tried to convey the informal conversational tone that we recommend. The word "parent" sounded stilted and formal, and, fearing that uninitiated users would attempt to adopt the wording uncritically, we chose to use only the term "mother."

1. Outside trips

This is a good topic with which to begin the interview, with a comment such as: *"A child as young as (name of child) ties a mother down much of the time. Do you ever manage to get away by yourself?"* If the reply is affirmative, ask, *"Who takes care of (name of child) when you are away?"* (Item #20). If the reply does not indicate that the mother has a regular person or small group of persons, ask: *"Can you usually count on her (him) or do*

you have to get a different person each time?" (Item #20). In her answer she might indicate that she goes out only when the father is home, and with just a little bit of additional questioning you can use this lead to get the information needed for Item #41.

This opener leads logically into a probe which relates to places the mother goes and takes the child with her, viz.: "Give me some examples of places you go and take (name of child) with you." Unless mentioned spontaneously, ask about the grocery store, doctor's office or clinic, relatives, etc. The inquiry about relatives can be followed immediately by a question such as, "How often do relatives come to visit your family?" Note that if the mother says, "I take him with me over to my mother's apartment two or three times a week," there is no need to ask whether relatives come to visit. The intent of Item #44 is to determine whether the infant has contact with some members of his or her extended family, and it does not matter whether that involves going out or having other people come to the apartment or house. Before leaving the area of excursion outside the home, be sure to ask about frequency of such activities.

If the mother describes a high frequency of outside trips, including possibly walks in a stroller, there is no need to inquire about whether the child gets out of the house four times a week (Item #22). If, however, the mother says that she seldom takes the baby with her on her own trips, it is necessary to inquire about such excursions, viz.: "Do you ever take her out

in the yard and put her in a play pen, or walk her in a stroller?
About how often?"

2. Toys and learning materials available to the child.

Inquiries in this section of the interview can be taken directly from the Inventory items. The interviewer might begin by saying something like, "I'm interested in knowing something about the kinds of toys and play materials (name of child) likes to play with. Most people feel that toys and play materials have a lot to do with helping a child learn." The mother will probably begin by mentioning specific toys which you can then classify as to whether they adequately represent one of the Inventory items. If she does not mention the items spontaneously, ask about each type, taking the wording from the individual items. A friendly Visitor will find opportunities to praise the mother for her concern about proper play materials or will say something like, "I bet he has enjoyed that." The Visitor will have to judge from the objects listed whether the toys would challenge the child to develop new skills (Item #40). At the end of this section, if it is not visible, ask (Item #25), "Where do you keep her toys? Have you set aside some special place for them?" This is one of the places in the interview where it is easy to inquire about the two items dealing with children's books. If you have seen some children's books you might comment, "I noticed that you have some little children's

books. Do you ever manage to find time to sit down and read to her?" If the answer is affirmative, ask, "About how often does he like you to do that?" If you have not seen any children's books, you might inquire, "Does (name of child) keep his/her books with the toys or is he/she not into looking at books yet?" These questions will help you score Items #42 and #45.

3. Family Routines

In this part of the interview you will be trying to learn whether the mother manages to give some time and attention to the young child as she carries out her routine household chores, whether she makes additional time available that is just for the child, and whether the father is involved in the child care routine. A good beginning is something like the following: "One of the hardest things about having young children around the house is that they are always demanding attention and you have a lot of other things to do besides pay attention to them. For example, how do you arrange things while you are doing the dishes (or the laundry, or cleaning house)?" What you want to learn here is whether the mother permits the child to be involved with her in these tasks and whether she makes the effort to help structure his play periods without demanding that he do all of this on his own. Helpful questions would be: "When you do housework do you concentrate entirely on it, or do you sometimes make conversation with (name of child) as you do your work (Item #36)?" "How does he get started playing with his toys? Do you

let him select what he wants to do, or do you make some suggestions to him or maybe get out certain toys (Item #39)?" Then it is essential to learn whether the mother finds time to do some things that are especially planned for the child, e.g., "Do you like to sit down and play with her sometimes?" If mother says yes, ask her, "Can you give me an example?" Also ask, "Does she like for you to do that, or does she prefer to play with her toys by herself?" From her description of her actions and the kinds of play in which she engages with her child, you will be able to determine whether she is consciously encouraging developmental advance (Item #37).

In this part of the interview you will usually learn spontaneously whether the mother permits the child to engage in "messy" play activities (Item #7). If not, a question must be phrased for this item, e.g., "Babies (or children) of this age usually love to play in things that get them all messy and dirty--mud, water, their food, and so on. Does he/she? How do you feel about it?"

While discussing the daily routine one can also secure the information necessary to code items dealing with meal patterns, e.g., "How do you manage meal times at your house? Do you feed (name of child) at the table with the rest of the family, or do you feed him/her separately (Item #43)?" If the information does not come forth spontaneously in response to that question, ask, "Is her/his father there for at least one meal each day?"

One other item requires information about whether the young

child has contact with a father or father figure. It can be asked about by using essentially the wording of the items: *"Does his father (Does your partner) give you some help with (name of child)? Does he do this kind of thing regularly and for at least ten minutes or so each day?"* Some have objected to these items on grounds that many infants are being reared these days in fatherless homes and that the presence of such items automatically penalizes such children. In spite of these objections the items have been left in because they were good items psychometrically speaking and because availability of a father to a young child is indisputably one indicator of the quality of the home environment.

The questions around family routines is another good place to ask about children's books (Items #42 and #45) if you have not obtained this information previously. For example, you might say, *"It sounds like you all have got a pretty full and busy schedule from day to day. Does it ever allow you time to read to (name of child), etc.?"*

4. Training and discipline

The final area which will need to be dealt with in the interview, unless it is covered by the mother's spontaneous remarks, relates to the use of physical punishment. Most of the items in this area are observational, and only one requires information relating to time prior to the visit (Item #15--"No more than one instance of physical punishment occurred during the

past week"). Obviously it is important that questioning in this sensitive area not be construed as threatening or judgmental. A good approach is to inquire in down-to-earth language, "In general, does he/she mind you pretty well? Or do you have to punish him/her to get him/her to mind?" If the mother says something like, "I have to spank his hands (or bottom or legs) to get him to (do something or stop doing something)," follow up with, "Think about last week and tell me how many times you had to do this during the week." If, in her answer to the question, the mother has not referred to spanking as her technique of discipline, the interviewer can inquire directly about the mother's attitudes, viz., "The mothers I talk to have different opinions about spanking a child as young as (name of child). Some say it is the best way, and others are opposed to it. How do you feel about this?" Then, if she answers with anything other than a declaration that children should never be spanked, inquire about frequency during the past week (Item #15).

VIII. SCORING

All items on all forms of the Inventory receive binary scores--yes or no. No attempt is made to make finer gradations. Although the HOME Inventory is administered ideally at the beginning of the 15-month home visit, scoring is based on information that may be obtained (observed) by the Visitor at any point throughout the visit (with the exception of the videotaping segment).

Except for those items where scoring criteria leave no room for leeway, the standard rule of thumb to apply in scoring is "what is appropriate for the target child." Decisions about scoring must be made from the child's point of view. It matters not that the parent's "heart is in the right place" or that "she is doing a great job under the circumstances." What matters is what gets to the child.

The final thing to consider in scoring is to stick to the content of each item. The HOME is a standardized procedure. Like most other measuring devices, it contains a sampling of items from a much broader domain. Nonetheless, it is that particular sample that forms the "standard" of comparison. If the item says "Parent takes child to grocery store," visits to a department store do not count. If the item states "Parent arranges for child to get music or art lessons," lessons provided in the school do not count.

Once individual items are scored, it is a simple matter to derive scores for subscales and for the total scale. The number of "Yeses" is simply added to get the score. However, the Data Center will be responsible for deriving the scores for the subscales and the total scale.

IX. HANDLING UNUSUAL CIRCUMSTANCES

A. What should the Visitor do if the mother begins to get restless during the interview?

The key to dealing with the problem is prevention. If you

have given the parent an indication of how long the procedure will take, this generally should not happen. Additionally, if the Visitor uses the proper style in conducting the visit, restlessness should not be a problem. Restlessness occurs more often when: (a) the interview seems too much like just a series of questions to which the parent must supply answers; (b) when the Visitor dominates the interchange. Don't be afraid to let the conversation wander a bit even into areas not covered by items on the HOME. The situation will seem more "real" and answers are likely to be more candid and complete. Don't be afraid to let the parents talk about things they are interested in. It is easy to get back eventually to the topic covered in the items. Don't be afraid to disrupt the interview for a while: to engage the child, to move physically from where you are sitting, etc. The Visitor is a manager, not a technician. She must sense when to change gears, change directions, change style or tempo. The goal is set. The Visitor must use insight and creativity to reach it, not force, or rigid adherence to a script. However, if she detects this reaction in spite of very careful preparation, it is good to offer to discontinue the interview and to arrange for another appointment. Most likely the mother will suggest that it will be all right to go ahead and complete it while the Visitor is there.

B. What should the Visitor do if she senses that the mother is trying to report what she thinks she should

be doing with her child rather than what she actually does?

A good indication that this kind of parent has been encountered will be frequent questions such as, "What do you think about that--am I doing the right thing?" An attitude of honesty and ingenuousness on the part of the Visitor will be important here. That is, she must communicate the idea that we have some ideas about conditions that favor the development of children but do not have any hard and fast knowledge. The Visitor will try and convince the parent that the knowledge she supplies will be helpful to us in our attempts to understand the relationship between certain conditions and the development of children. The Visitor's ability to convey this philosophy will probably be affected by her own attitude or understanding of the intent of the interview. If it can always be remembered that the intent of the procedure is to describe rather than evaluate to get information rather than express opinions or make suggestions, the Visitor will not too readily fall into this trap. One should not think in terms of the respondent's "passing" or "failing" HOME items or the HOME as a whole. In the generation of the items an assumption was made that certain experiences and objects, if present or absent in the daily life of a child, can make a difference in that child's social and cognitive development. These hypotheses are based on theories of human development and research on children's environments. However, the items in the scale are based on general principles of human

development. These principles are not equally applicable to all children. Moreover, not all items retained in the final version are equally sensitive; some appear to have less impressive psychometric credentials than others. Therefore any mother who is concerned about her response to one particular item should be reassured on this matter by the fact that we do not have positive proof that any one of these conditions is essential for nourishing child development. We confidently expect that in future analyses of the items we will find some that do not correlate significantly with the child's development, in which case they will be replaced. Relatedly, the home environment of a child may include some compensating factors not currently indexed on HOME

X. TRAINING AND CERTIFICATION

The purpose of this section is to specify procedures for determining when a home visitor is adequately trained on the HOME Inventory. Standards are established in two areas: 1) scoring of individual items, and 2) general approach to administration. It is essential that both be evaluated in making a determination of whether a Visitor is adequately prepared to use the HOME in the NICHD Study of Early Child Care since there is need to ensure both validity of individual measurements and comparability across measurements. Since what is being evaluated in these two areas is different, the approaches to verifying that standards are met are accordingly different. For area #1, a precise target is set

for match to standard (we are requiring a 90% match to standard.) For area #2, which includes style issues as well as skill issues, a more general appraisal will be used that involves rating the visitor on behaviors used when administering the HOME

A. Procedures for Certification at Individual Sites

To begin the certification procedure, each site should designate a member of the staff to be the home visit HOME trainer. That person, after studying the manual, should do a home visit and administer the HOME. The entire administration should be videotaped. The designated trainer should submit this videotape, together with a score sheet, to the Little Rock site. Scoring should be based solely on what can be seen on the videotape. Each item on the score sheet should be marked "Yes", "No" or "Did not obtain sufficient information to score". Scoring should be based exclusively on what is obtainable from the videotape, not on observations made during the visit that are not recorded. The Little Rock site will evaluate scoring accuracy and style of administration using the procedures outlined in Section B immediately below. Should the person designated as trainer not meet certification criteria, a "second chance" will be given.

In order to maintain cross-site consistency in administration and scoring, every one at each site who administers the HOME should submit new tapes and accompanying score sheets every four months for evaluation to the Little Rock

site.

B. General Certification Procedures

1. Scoring

A certification videotape has been developed by the Little Rock site. Criterion scoring has been developed for each item based on information contained in the videotape (yes-no-insufficient to score). In order to be certified as trained, a visitor must be in agreement with scoring on 41 of 45 items. A second tape will also be made available with criterion scoring provided to serve as a "second chance." In addition, since a single tape cannot include all that one sees in a "real home visit", the person being certified will accompany a trained home visitor and will administer the HOME in a real setting. The trainer and trainee will independently score the HOME. The trainee must agree with the trainer on 41 of 45 items. Trainees must meet both standards in order to be certified as trained.

2. General approach to administration

In a very real sense, the validity of the HOME depends on the quality of the interaction between the home visitor and the family being assessed. The visitor must essentially be a conduit through which the family reveals those things about themselves needed to score individual items. To a far lesser degree, the home visitor may need to be a stimulator or manager of events so that the "the minimal demand requirements" of the technique are

met. The staging of the HOME must be such that families are afforded an opportunity to be themselves with the least infringement and direction as possible. There is no one "right way" to administer the HOME. The visitor is the instrument through which the general strategies included in the HOME technique "work." However, there are types of visitor behaviors that seem better suited to maximizing the validity of the technique. The Little Rock site has developed a checklist of home visitor behaviors to be reviewed in making an overall appraisal of the degree to which families were allowed to reveal who they are and what they do. The appraisal checklist contains eleven items. It covers such issues as whether or not sufficient probing was done to get the information needed to score items, whether the Visitor posed leading or embarrassing questions to the mother, whether the pacing of the interview allowed the mother to act in a normal manner, whether a friendly yet businesslike approach was used, whether a non-judgmental attitude was manifest, etc. It also includes such things as whether the visitor used good listening techniques, encouraged the caregiver to talk about herself and her children rather than simply responding to questions whether "evaluative" type statements were made, whether the pace of the visit was determined more by the family or the visitor, body language, intrusiveness, naturalness, sincerity, respectfulness, projection of comfortableness, etc. Each behavior on the checklist will be rated on a 5-point scale and an overall score derived. To pass the certification, the

Visitor must attain at least 33 out of 55 points on the rating scale and must receive no ratings of "1" on any of the items.

Chapter 15

Section 3

PROCEDURES FOR VIDEOTAPING MOTHER-CHILD INTERACTION

AT 15-MONTHS

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Chapter 15

Section 3

PROCEDURES FOR VIDEOTAPING MOTHER-CHILD INTERACTION AT 15-MONTHS

I. OVERVIEW

We are videotaping a mother-child interaction during the 15-month home visit in order to assess the quality of mother and child behavior during a playtime. Videotaping their interaction will enable us to rate the interaction by coders who are "blind" to other information on the families, and uninfluenced by biases that might develop as a result of interviewing the mother in her home. The rating scales to be used with these videotaped observations parallel the Qualitative Rating Scales that are used in the live ratings of the children's interactive experiences in child care. We are primarily interested in dyadic qualities and maternal affect, sensitivity, involvement, intrusiveness, and stimulation, and the child's affect, sociability, attentiveness, and activity level. It is recommended that home visitors review these scales (See Chapter 15.4, Appendix E.) A basic familiarity with these qualitative scales prior to conducting the home visit should provide some basis for on-the-spot decisions that might need to be made while videotaping the interaction.

II. GENERAL INFORMATION AND GUIDELINES

Under typical conditions, the videotaping of mother and child in the home at 15-months will follow the administration of questions from the HOME Inventory and precede the administration of the remaining interview and questionnaires. At the beginning of the visit, as well as during the 13-month telephone call to set up the entire visit, the mother will have been informed that videotaping will take place.

The videotaping of mother-child interaction will take place following a short break from the administration of the HOME Inventory, to enable the mother to take care of anything that might intrude on the videotaping (e.g., changing diaper, checking on other children, going to the bathroom, feeding the child). To minimize total time in the home, the video equipment should be set up by the second visitor during the administration of the HOME, whenever possible. When there is only one visitor, she should set up the equipment during the break following the HOME Inventory.

The videotaping will consist of one 15-minute session of mother-child play with toys contained in 3 cloth bags. Specific instructions for the task follow below. The main objective of this task is to provide a structure for observing mother-child interaction in the context of play by specifying that the child is to play with the toys in the bags starting with a specified bag.

Early termination of taping should occur when the mother explicitly requests it, or when the mother is resentful, angry, or hostile ABOUT THE TAPING. In these conditions taping may of course be stopped earlier than the 15-minutes, but to be coded there will need

to be a minimum of 10-minutes of taping.

The area in which you place the three bags will define the general location for the interaction. The child is to stay in the room in which the toys are located, and this will be explained in the instructions given to the mother, as detailed below.

Throughout the episode it will be the camera person's job to capture the child and mother on videotape, using the video camera, tripod and battery pack that she brings to the visit. Technical details on taping are supplied below in a separate section.

Important to point out at this juncture is that the camera person is to act in a detached manner throughout the taping, rather than as an avid observer or participant. The camera person, who was formerly an interested visitor with the mother must now transform herself into a technician. This means that the camera person should not make herself especially available to mother or child. This can be accomplished most easily by avoiding, for the most part, eye contact with those being observed.

Any response from the camera person will be a reinforcer for the child to continue interacting with the camera person. The camera person should not be rude, however. If, for example, something funny happens and the mother looks at the camera person, she should feel free to smile back, but nothing more. Do not extend such psychological contact. Similarly, if something distressing to the child occurs and the mother looks up to the camera person, sharing an empathic facial expression is permitted. However, it is important to signal that the camera person's focus is more on the filming process

than on any interaction with those being filmed. The goal throughout the session is to be detached and uninvolved, yet not make mother or child feel uncomfortable. Minimum interactive involvement can often best accomplish this goal. Details about handling difficult situations are provided below in the section labeled "problem solving."

It will be the second home visitor's job, during the videotaping, to occupy and entertain potential intruders (including pets!) so that they don't disrupt the videotaping session. A section below describes the job of this individual.

III. MATERIALS

Toys for the procedure will be specified by manufacturer number and source in time for the official pilot. Each site will be responsible for ordering their own toys; bags will be provided for those toys by the Dallas site. (Until these are available, each site can approximate the toys that are specified.) These toys should not be present during other parts of the 15 month lab visit, i.e., they should be novel for the child.

The principles underlying the selection of the three toys were that we wanted them (a) to be interesting to children of this age, (b) to foster different types of activities, and (c) to have the potential of being used differently by the children and their mothers. Mothers can attempt both age appropriate and inappropriate activities with each toy. Each toy is placed in a cloth bag (about 24" x 36"). (Pillowcases may be used for pilot visits.) In the lab procedure on

which this home procedure is modeled, the toys were in boxes placed on a table so the mother could control access to them. The cloth bags, pulled closed, will also allow the mother to control access to the toys.

Bags will be purchased and shipped to each site in time for the official pilot. A large, legible number "1", "2" or "3" will be drawn on each bag. Sites will be sent four sets of the bags. RAs at the site will affix cords to the bags to enable the bags to be "drawn" closed. To easily carry the toys into the homes, place each toy in its designated bag, then put two of the bagged toys into the third bag. Pull bags 1 and 2 out of bag 3 before you begin videotaping.

BAG 1. Story Book. (To be purchased by sites) The pictures should tell a story. Snow (1989; 1990) and Vandell (1979) have used a picture book in context and find wide variations in mothers' language about the book, in children's interest in the book, and in how mothers structure the task. (Some mothers hold their children while they "read"; others place the book on the floor and then step away; others read while facing the child a la the teacher mode). The book is also interesting because it allows us to see (a) how mothers handle the transition if the children are not interested in the book and (b) how rich the child's language environment around books might be. A specific book has been chosen (Good Dog Carl), and sites will order 10 copies from Scholastic Books. (Sites are instructed to order 10 copies, since the books are paperback and may not last through more than 10 to 15 presentations.) Clear contact paper should be placed over each page of the book to allow the books to be washed after each

visit

BAG 2. Toddler Kitchen (Fisher Price Model number 1035, 1990, to be purchased by sites.) This toy set includes a model kitchen along with four accessories: a mixing spoon, a frying pan, and two pieces of toy "food". The pan can be put in the stove, the spoon can be hung on the side of the kitchen, and the food pieces can be put through the holes like puzzle pieces. The doors can be opened, the "burner" can be spun, and the toast can be pressed into the toaster. Present the toy in the bag with the accessories in the "oven", and return the toys to the oven for storage. This toy can be used in various ways: including manipulative play, functional play, pretend play, and naming.

BAG 3. Discovery Cottage by Fisher Price (to be purchased by sites.) This house comes with three "tubby" figures and a car. The roof can open and reveals a mirror. The figures can be inserted in the chimney and they come out the side of the house. The figures can fit inside the garage that opens and closes. Children are very interested in this toy. It has potential for pretend play and also manipulative play.

The toys will need to be washed with dish washing liquid after each use. The books pages should be wiped lightly. According to pediatricians, dish washing liquid kills just about anything, including bacteria and fairly virile viruses like hepatitis. The bags should also be laundered after each use so that the cleaned toys are placed into clean bags.

As noted above, the visitor will also carry with him/her, a

portable video camera and a battery pack so that the video camera will not have to be plugged into a wall socket. In addition, the visitor will bring two videotapes, one for taping the session and another as back up in event of problems with the first. The visitor will also have a magic-marker and small wipe-off marker board of the kind often placed on walls next to telephones for writing (and erasing) messages. It will be used to record the ID number of the family, the age of the child and the date of videotaping (in that order, vertically listed) which will be recorded at the beginning of every taping session for identification purposes.

Finally, the visitor will bring a Videotaping Record Form and a Videotaping Rating Form to complete before and after the taping. These forms are provided in the Appendix of Chapter 15.4.

IV. INSTRUCTIONS

Attempt to find a place to videotape that 1) looks like a relatively comfortable place to play, 2) has good lighting, 3) will allow mother and child to be relatively alone. Enlist the mother's help in finding a good place. If there are 2 visitors, the second one should set up the video equipment during the HOME Inventory, if possible. If there is only one visitor, she should set up the equipment following the HOME and during the break that is offered to the mother (see below).

At the end of the HOME Inventory, the interviewer initiates transition to the videotaping session by conveying the following:
"That's all I need to ask you about for now, but we'll have an

opportunity to talk some more a little later in my visit. Now, if we can, I'd like to videotape you and CHILD together for approximately 15 minutes. After this we will sit together and talk some more.

Remember, this is a time for just you and CHILD and we want to keep out all intrusions that we can. Before getting started with the videotaping I want to give you a chance to take care of anything that you think could interrupt our taping. If you think CHILD needs to be changed or fed something, this would be a great time to do it. While I am setting up (finish setting up) the camera you might also do anything you need to do for yourself before we begin. You also might want to let other family members know that you'll need some time now with CHILD without interruptions. In fact, if the phone rings or someone comes to the door, would it be okay if OTHER VISITOR took care of these interruptions and request that someone either call back or wait until we are finished? OTHER VISITOR can help with the children. He/she has brought some interesting things that should keep them busy). Where might be the best place for me to set up the camera (and for the children to spend some time with OTHER VISITOR)?"

At this point, transitional details are taken care of (such as mother taking care of her needs and other children becoming involved in alternative activity.) If camera has been previously set up by visitor two in a room different from where the HOME Inventory has been given, ID information will already be recorded and checked. If set up in the same room, record this information now and check it by playing this back to check camera's video and audio functioning. In its entirety, this transitional period should last no longer than 10

minutes. Once the camera is set up and people other than mother and child have been taken care of, the visitor should begin recording. Videotaping commences as soon as the visitor begins the instructions to the mother.

As soon as the visitor turns on the camera, she should make note on the VIDEOTAPING RECORD FORM of the time the taping started (question 2). Before the visit, she should have indicated the date of the taping (question 1). During the taping she should note any interruptions in the taping and the start and stop time of the interruptions (question 3). Finally, after the taping has been completed she should note the time of completion (question 4) and any unusual circumstances (question 5). Finally, the visitor who did the taping should complete Videotaping Record Form and the first section of the Post Home Visit Ratings of Mother and Child Behavior (appendix B.#.C of Ch 15.4) after the taping has been completed. A good time to complete this form might be while the mother is filling out the questionnaires following the first part of the interview.

The mother-child interaction procedure will be coded at the Timberlawn Foundation in Dallas using the qualitative scales. Consequently, it is important to include both the mother and child on the screen whenever possible. Do not focus solely on the face of the mother or child. It is important to have the whole body of the child on the screen.

At the beginning of the procedure, the mother is told (verbatim):
"This activity will take about 15 minutes. We would like for your child to spend some time with each of the three toys in the bags."

Please have CHILD start with the #1 bag and finish with the #3 bag. During this activity, you may play with CHILD if you would like."

"Before getting started, I should say that I will be trying to get both you and CHILD on the videotape. Try to keep CHILD's activities confined to this room. I may need to move around a bit, but just try to ignore me. If there is some unexpected interruption, OTHER VISITOR (I) will try to handle it so your time with CHILD and the videotaping are not interrupted. Do you have any questions before I get started?" (If yes, answer them.)

If mothers ask how long to spend on each toy, the visitor should respond, "You can divide the time as you like."

If a mother asks if she should open the #1 bag first, the visitor should respond, "We would like you to give CHILD the bag with #1 on it first."

If the mother asks if she can play with the child during this period, the visitor should respond, "That's completely up to you. Do whatever feels best to you."

If the mother asks if she and the CHILD should play with all 3 toys in the bags, the visitor should respond, "Yes".

If mother has no questions, or after you have answered her questions, say, "I'm ready to start taping. You can begin at any time."

Note that the visitor does not tell the mother that she has to interact with the child nor is the mother told how long the child must spend with each toy. These purposefully ambiguous instructions allow us to see (a) how sensitive mothers are to their children's interests

and needs without clear instructions from the experimenter, (b) if mothers appear either uninvolved or intrusive in the face of ambiguity, and (c) how mothers handle the transition from one toy to another. We can also focus on aspects of the children's behavior as reflected in the qualitative scales (e.g., positive and negative affect; sustained attention, activity, etc.). Finally, the measures of the quality of the mother-child dyads such as mutual engagement can be rated.

When the videotaping is over: *"Okay, I've finished videotaping. Thank you for letting us videotape CHILD. What I want to do right now is briefly check the tape by rewinding it and looking at the last seconds of it to make certain that it recorded you and CHILD. On occasion we have had mechanical trouble. Feel free to take a break as we did before and I will make sure every thing is okay. If I find a problem, I may have to ask that we do the taping again, but I doubt that I will."* (If there is a problem, see if it is correctable and set the videotaping session in motion once again if a total of 10 minutes of mother and child together have not been recorded.) *"In just a couple of minutes we will need to sit down again so that I can ask you some more questions."*

V. THE OTHER VISITOR

In homes in which there are other young children, it will be necessary for the other visitor to keep the children occupied and out of the way of the data collection following the administration of the HOME. To do this well, the individual will need to be introduced to

mother and children and mother's assistance will need to be recruited to let the children know that this person will be caring for them while the mother is busy. This should be done early in the visit, with the data collector asking mother to explain to the children that after awhile she will be too busy and involved to be with them and so for that time [VISITOR 2] will play with them.

The other visitor may also need to visit with the father or other adults in the home during the videotaping in some other part of the house to keep the procedure standard.

It will also be the other visitor's responsibility to answer the phone and/or the door or to deal with any other interruptions that might arise once the videotaping begins. The other visitor should always be courteous, explaining who he/she is (a research assistant with a particular university assisting the visitor and/or watching the children because mother is busy with a research project) and that mother is tied up but that he/she would be more than happy to take any messages that need to be transmitted. Before the taping starts, he/she should ask what message the mother would like her/him to give callers (e.g. when the mother wants it said that she will be able to call back). Ask also if there are any callers for whom the mother would like to be interrupted. Within the constraints given by the mother, this individual needs to convey to callers that unless an interruption of the mother cannot be put off, that the mother has requested that any interrupter get in touch with her at another time.

The visitors should bring a canvas bag with a variety of age appropriate materials for children ranging in age from about 2 to 6

years. Especially useful are coloring books with tear out pages (to be left with the child), washable crayons (in reasonably good condition), paint-with-water books with tear out pages, picture books, characters (preferably non-action oriented) and other easy to manipulate, hard-to-swallow objects that can be employed in games of pretend or make believe. In addition to coloring books, it is also useful to have blank paper for drawing and folding. To the extent possible, these materials will need to be wiped off with dish washing detergent and rinsed after each use.

VI. PROBLEM SOLVING

Any number of circumstances can arise which could potentially derail the successful implementation and completion of the videotaping of mother-child interaction in the home. Listed below are several possible problems that might be encountered and recommended solutions. It is impossible to anticipate all potential problems; the data collector should thus maintain an attitude that permits "thinking on his/her feet" in order to successfully confront challenges that might arise. Foremost to keep in mind are the needs of the mother, child, and family and our desire to obtain high quality data.

Solutions that seriously discomfort families and breed resentment which could undermine further participation in the project must be avoided. At the same time, however, the data collector must be prepared to work hard to find a solution that will enable him/her to obtain the data that is needed.

A. Video Malfunction

The videocamera should be tested before the initiation of taping and at the presumed end of taping. If the video malfunctions at the outset and cannot be fixed, proceed to the next phase of data collection.

Do not spend an inordinate amount of time trying to fix a problem, as this could unduly lengthen the visit and/or interfere with the smooth efficient collection of the remaining data. If a problem is identified at the end of taping, determine how early it started. If more than 10 minutes of tape (with audio) have been collected, there is no need to make alternative arrangements. If less than 10 minutes of good videotape have been collected AND the problem can be fixed, try to get the mother to engage the child in interaction again so that at least 10 minutes can be recorded. If the problem cannot be fixed, apologize to the mother, let her know that you would like to reschedule at a later date, but that you will talk with her more about that once this visit is completed.

Then, proceed to the next phase of data collection.

B. Unexpected Interruptions

The other visitor should try to deal with all interruptions if at all possible; for example, by answering the phone or the door. Try to discourage an unnecessary interruption of the mother, unless there appears to be an emergency situation.

If the interrupter won't be put off (e.g., insists on talking to the mother or coming in), consult the mother about what she wants to

do and act in accord with her wishes. If interruptions of the mother with the child last less than 30 seconds, just keep filming. If, however, the interruption lasts longer, or if there is no second visitor and the camera person must leave the camera, stop the camera. Restart when the interruption is resolved.

If the mother must leave the room to deal with the interruption, stop the camera and resume taping when mother can return.

Of course, if there is clear and present danger of some kind, take necessary protective actions.

GENERAL PRINCIPLE: Whenever a later restart is called for (after some intervening period of some length-->10 minutes) because a full 10 minutes of taping was not completed, start entire process over from the beginning. Don't erase what has already been collected, just seek to obtain a full 15 minutes more.

C. Maternal Interruption

If the mother requests/demands to stop for any reason, approve automatically if more than 10 minutes of taping of has taken place. Then terminate and restart for the final 5 minutes if you can. If less than 10 minutes has gone by, let the mother know that you need only a little more time and seek her approval to continue until at least 10 minutes have been taped. If she seems resistant to, or resentful of, such a request, terminate taping and try to restart if possible when she is ready. If she does not want to do anymore,

respect her wishes.

D. Maternal Refusal

If the mother says she does not want to do the videotape, remind her that other families have found it enjoyable, that parts of these tapes will be put together and given to her at the end of the study as a gift, and that no one other than research staff will view the tape. The goal here is to try to be "softly" persuasive. Empathize with her discomfort ("other mothers have felt that way"), but try to enlist her willingness. If you think that will put the mother off, go on to next phase of data collection and return to possibility of videotaping once that phase is over.

Remember, all parents have been informed that they can refuse any part of study that they want to, so persuasion has to be "soft." If a mother refuses such efforts, respect her sentiments and be sure to point out not only that it is okay, but that we promised her in the beginning when she signed informed consent that she retained the right to any and all refusal. We don't want her feeling bad about letting us down.

E. Child Makes Taping Impossible

It will not be possible to complete the mother/child interaction procedure if the child persistently refuses to stay in the room, absolutely refuses to leave the camera alone, falls asleep, or is ill during the visit.

If there are physical reasons (i.e. falls asleep, very sleepy,

ill, etc.) that would interfere with conducting the mother-child interaction, terminate (or do not begin) the interaction procedure and attempt to reschedule another visit for the videotaping. Proceed with the other parts of the home visit.

If the child is fussy, wanting to leave the room, very interested in the camera, or otherwise acting in ways that suggest the interaction may be difficult to complete, you should still start the procedure. Occasionally children are restless or resistant to staying in the room at the beginning of the mother-child interaction procedure, but the difficulties tend to resolve once the interaction begins and the mother encourages the child's interest in the bags and toys. If after 5 minutes of filming the child is still actively struggling to leave the room (and not just wandering away from mother occasionally), then terminate the procedure saying something appropriate like, "This looks like it's not working very well for CHILD right now. Why don't we stop and see if it works better a little later." Proceed to the next part of the visit and attempt the mother-child interaction procedure again after completing other parts of the visit. If the child responds similarly in your second attempt, terminate again. Discuss with the mother if she thinks another day or time might work better. You will have to decide if it is worth trying to reschedule. You should discuss contingency plans with your PI or PC.

If the mother-child interaction procedures can not be completed this is indicated on form 15X, the Home Visit Report.

F. Unwanted Observers

There may be occasions when someone wants to observe who is capable of sitting quietly and just watching. Fathers will be most likely to want to do this--and understandably so. Let them know in the most courteous of terms that we would rather have no observers because this is how all mothers and children are being videotaped and that doing something different in this home will upset the scientific consistency we are trying to achieve. If this fails, simply request that the individual sit quietly as far away from the taping as possible and not become involved in any part of the taping. Should the individual seek to become involved, remind him/her of the methodological requirements of not interrupting. If this fails after several occasions, or evokes verbal or nonverbal angry or hostile reactions, simply continue taping. We do not want to seriously alienate families or place mothers in untenable positions. Such situations should always be reported on the Videotaping Report Form. If the individual repeatedly interrupted, you may want to call the mother back to reschedule a videotaping when others will not be present to interrupt and involve themselves in the interaction. Consult your PI or PC before doing so, and do so only if it is judged that a second session will not alienate families or place mothers in untenable positions.

G. When the Child is No Longer in the Mother's Custody

If the child is no longer in the mother's custody, the mother-child interaction procedure can be done with the child's current custodian (who will likely be the informant in this visit). It is

important to code the REL code to correctly indicate the person observed in this procedure on the Videotaping Record Form Home Visit (15S) and comment in #5, unusual circumstances.

If an additional visit is scheduled to videotape the mother-child interaction, the Videotaping Record Form Home Visit (15S) would be completed only at the visit when videotaping is accomplished.

VII. TECHNICAL CONSIDERATIONS

A. Where to set up camera

After locating a place to videotape the interaction that will be relatively quiet and free from disturbances, you should determine where to place the camera. Position the camera as far away from the action as possible, still allowing you to get a good picture and sound. Remember that the closer the camera is placed to the mother and child, the more likely that she and the child will remain conscious of its presence. You will use the zoom lens to bring the mother and child into the appropriate range, rather than the actual placement of the camera. You may have to move furniture a little. If it looks like moving furniture would help in finding a location for mother, child, and camera, check with the mother first to be sure it is all right with her. Do not attempt to move anything large, like a sofa or a dining room table. You want to be careful not to harm either the furniture or yourself.

In some homes, of course, there will be no option on where to place the camera. In cases where you must have the camera set up close to the mother, it will be particularly important that you "set

the stage" for the videotaping by psychologically distancing yourself from the interaction that will take place.

Sometimes children are distracted by the red light on the camera indicating that recording is occurring. Sites may want to cover this light with a small piece of tape.

If filming during the day, be sure that you do not film into a window. This creates back lighting and faces too dark to see their expressions. Use artificial lighting generously but do not film into a lighted lamp. Lamps should be lit on either side of the mother and child preferably between mother/child and camera but not directly behind them. Use "studio lights" or a camera light attachment for additional light if necessary.

B. Using a tripod, battery pack and an earphone

With the mobility of a 15-month-old it may not always be possible to use a tripod in videotaping. A monopod is more easily moved than a tripod, allows a steady picture, and is less fatiguing than holding the camera; it also allows production of a picture that is at eye level of the mother and child (rather than a picture showing mostly tops of heads). If you must hold the camera without tripod or monopod try to film from a seated position to be at the correct height for filming at eye level. A "campstool" will work well for this purpose. Be prepared for fatigue. The session is to go for 15 minutes straight without break.

The camera should be operated from a battery pack so that an electrical outlet will not constrain the placement of the camera and

so that there will be no constraints on moving the camera once the observation has started.

To be able to check that the audio is properly functioning, it will be necessary to use an earphone in the audio jack of the camera and listen for sound. This is essential. A picture without sound is uncodable.

C. Filming identifying information on the tape

As part of the setup procedures film a sign on which you have written 1) subject number, 2) "15 Month Home", 3) date, and 4) approximate time started. Double check that the correct subject number is written on the sign.

This information can be on an erasable board you have brought to the visit. Film the board while you read out loud the same information. Rewind the videotape and play it back, checking that the camera is operating properly.

Set the time clock (date is not needed) on the camera so that this will also be recorded on the tape during the interaction. If the time label gets in the way of clearly viewing mother or child (especially if it covers a face), turn it off. It is better not to have the time recorded throughout than to obscure important features of the interaction.

D. What the view finder should show

Keep both the mother and child in view, if at all possible. Stay close enough in (visually) to be able to see facial expressions, but

not so close that you miss gestures, body position changes, etc. Children generally express affect with their entire bodies (mothers, too, but usually not as dramatically). If at all possible, try to get both partners' facial expressions simultaneously. If, during the course of the interaction, both mother and child move such that they cannot be in the picture simultaneously, keep the child in the picture, zooming back as much as you can to try to get the mother in the picture while still getting child's facial expressions. If necessary pan to the mother periodically.

Make certain that the mother and child are in focus. Use auto-focus if you can be certain that nothing will come in between the camera and the mother and child, throwing your focus onto something extraneous. If you use manual focus, obtain a sharp focus by making adjustments with the zoom up close. Zoom back out to the proper distance for filming after focusing.

Once you have the appropriate camera location, zoom distance, and focus, make further adjustments only if necessary. Moving the camera after the interaction has started will unnecessarily call mother's attention to the fact that she is being taped. Tinkering with the zoom and focus over the course of the observation will make the coder's task more difficult.

However, it is very possible that you will need to make adjustments. Most 15-month-olds are very mobile, and you will need to follow the child. Try to keep the mother in view as well if the child moves away. Do this by first zooming back slightly for a "bigger picture" and, if necessary, moving the camera.

E. Number of observations per tape

It is more economical to put two observations on each videotape. However, the danger in this procedure is that more data would be lost if something happened to the tape. For this reason, we recommend that sites use one tape per home visit. When a copy is made (to be retained by the site--see below) multiple observations can be placed on one tape.

F. Labeling the outside of the tape

Tape identification information should be on each tape and tape box. It is important to label the outside spine of the tape and the box. The DCC will provide each site with labels containing the following information:

NICHD Study of Early Child Care

15-month Mother/Child

Site

Family's ID#

Date of taping (To be completed by the site)

Do not include any other identifying information on the box or on the tape.

Double check that subject ID is correct and matches ID filmed prior to the interaction procedure. Each tape must be checked before mailing for coding.

G. Copying the tape and mailing it to be coded

Each site should work out a process whereby a copy is made of

each videotaped interaction. The copy should be retained at the site and the original should be mailed for coding to the following address:

Dr. Margaret Tresch Owen
Timberlawn Research Foundation
P.O. Box 270789
2750 Grove Hill Rd.
Dallas, Texas 75227

Include a photocopy of the Videotaping Report Form for each tape mailed to notify coders of interruptions or unusual circumstances that occurred. Also include a "Interaction Video Shipping List (Form 15T)" listing all tapes enclosed. The tapes should be mailed weekly. There is no need to use Express mail. Mark Do Not X-Ray on the outside of the mailing box. Sites will be notified when and what tapes (by subject ID) are received. Notify Margaret Owen immediately if there is a discrepancy between what was thought to be mailed and what was said to have been received.

H. Training

The goal in training home visitors to videotape mother-child interaction is to ensure that the tapes document mother-child interaction in a way that enables independent scorers to rate qualities of the interaction. Picture quality and sound quality must be excellent. Training on videotape technique using examples of what constitutes acceptable and not acceptable videotapes of mother-child interaction will occur during the network training session on the 15-month home visit. Each trainee should make a videotape of mother-child interaction using the 15-month protocol and send it to Margaret Tresch Owen, Timberlawn Research Foundation, P.O. Box 270789,

2750 Grove Hill Rd., Dallas, Texas, 26227, for certification that videotaping techniques and procedures are acceptable. All personnel who subsequently become home visitors during the course of 15-month data collection must review training materials from the network training session and receive "certification" on the mother-child procedures from Margaret Tresel Owen.

Chapter 15

Section 4

INFORMATION REGARDING THE FIFTEEN MONTH STANDARDIZED INTERVIEW AND QUESTIONNAIRES

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She also played a large role in the design of the Interview.

Chapter 15

Section 4

INFORMATION REGARDING THE FIFTEEN MONTH STANDARDIZED INTERVIEW AND QUESTIONNAIRES

I. OVERVIEW

The Standardized Interview and Questionnaires are intended to follow the less structured HOME Inventory and the videotaped interactions at the 15-month home visit. However, as indicated in the overall guide for the 15-Month Home Visit (Chapter 15.1), this order of administration may be changed depending upon the situation in the home.

The Standardized Interview and Questionnaires are designed to collect specific information from all mothers in a systematic form using objective techniques and measures that have been used in other studies. By collecting data in this way, the data we collect can be compared to other data from families in previous and future studies. It is important that you follow all the guidelines listed in this manual.

The purpose of this interview at 15 months is to see what changes have occurred in the family since we last spoke with the mother at 12 months and to collect information about any changes that may have occurred. All of the mothers in the study were asked questions similar to these when their babies were 1 and 6

months old and again, on the phone, at tri-monthly intervals. Before you leave the laboratory to visit the mother when her child is 15 months, you will need to review the family's files from these previous interviews and you will need to enter information in the appropriate places on the 15-month forms.

Part I of the Interview consists of two sections: the first section asks about changes in household data and the second part asks about family health.

In Part II of the Interview, we are concerned with changes in the mother's and husband/partner's employment or educational status and feelings and attitudes about employment.

The third booklet contains the Self-administered Questionnaires for Parts I & II. Questionnaires included in this section are My Feelings, Parental Care, Relationships with Other People, Family Finances, Parenting Experiences, Combining Work and Family, Job Experiences, and My Child Care.

Also in this section, we give the mother a copy of the MacArthur language Inventory (Infant form) for her to complete and bring to the lab visit. Complete instructions for the form can be found in the Questionnaires section.

At this point, we also explain the Ear Infection Physician's Report form to the mother and ask for her permission to contact her physician or health care provider. If she gives permission, we collect her signature and the appropriate information on the forms.

Finally, we debrief the mother and update information on

contact names and addresses for the family in case we need help in locating the mother in the future. Detailed information about the procedures for collecting this information from the mothers and from the medical care provider can be found in section IV. G. 2. of this chapter.

II. THE INTERVIEW AS A SOCIAL SITUATION

Interviewing is a social interaction, a form of structured conversation that calls upon everyday social skills such as tact, attentiveness, and courtesy. In a standardized interview, the interviewer has a schedule of questions to be asked of the interviewee in an organized, structured manner that is the same across all interviews. Likewise, standardized interview questions are designed to be administered to all subjects in exactly the same ways.

A successful standardized interview depends upon the interviewer's attention to two major concerns: (1) establishing an appropriate context for the interview, and (2) minimizing interviewer-related error in the data collected. These two concerns correspond to the two aspects of the Home Interviewer's role: friendly visitor and professional interviewer. In this section, we discuss some general principles as to how an Interviewer can address these concerns. Some of our comments are taken from Chapter 7, "General Instructions," of the HOME. Visitors are urged to read this chapter thoroughly, because it contains a great deal of helpful information about interviewing

families in their homes and helping families to feel at ease. Other comments are taken from the IHDP Phase II Assessment manual. Comments regarding specific interviewing techniques and the minimization of interviewer-related error are taken from Fowler Jr., F. and Mangione, T. (1990) Standardized Survey Interviewing: Minimizing Interviewer-Related Error. Sage Publications, Applied Social Research Methods Series, v. 18: Newbury Park, CA.

A. Establishing a Context for the Interview

This interview should be one component of a pleasant 15-month visit with the mother. Before the home visitors begin the Standardized Interview and Questionnaires, they will already have visited with the mother and said several positive things about the mother's participation, about the toddler, and, possibly, about the home.

But an interview is more than just a friendly visit. Interviewing is a professional job that requires professional skills. The tone of your voice will convey your professionalism and self-assurance. Express genuine interest in what the mother tells you. Questions should not be approached in an apologetic or embarrassed manner. These questions have been used before many times, and they have not been found to be too personal or difficult. Many mothers have told us they enjoy the interview and questionnaires, and that it helps them to think about things they had not considered before.

The quality of your interview is critical to this study. You are the key factor in determining the quality of the data we obtain!

As much as possible, have the interview sound like a conversation. Because this is a structured interview, a conversational style is not an easy thing to achieve! The best way to achieve this is to be totally familiar with the questions and know what you're going to ask so you don't have the awkward problem of needing to "find your place." Establish a relaxed pace, and listen carefully to everything the mother has to say.

Show interest and positive attention to the mother. Look at the mother as she answers, nod, don't just look down for where to record the answer. Be careful, however, to avoid using terms such as "That's fine" or "Good" after the mother completes an answer. Even seemingly innocuous statements after the mother says something may subtly reinforce particular types of answers.

B. Neutrality and Confidentiality

It is important that you maintain a neutral attitude toward the mother's responses. Avoid behavior that could affect how the mother answers. For example, do not suggest answers, reword or interpret the question for the mother, except according to the specific guidelines described in this manual. Do not anticipate an answer to a question.

Avoid giving your opinion, even if asked. For how to respond to questions about the study, refer to the information we give the mother about the study in the brochure, in the two-week phone call script, and in the Informed Consent. Keep your answers here short and concise.

Do not let your tone or the pace at which you read the questions indicate that one answer is preferable to another. For example, do not read some response options faster or slower than others or read some with vocal inflection and others with a monotone.

A mother must feel free to speak candidly. In order for her to speak candidly, we guaranteed her (in the Informed Consent Form) that all the information that we collect about her and her family will be confidential and that all data will be kept confidentially, in a locked file cabinet. If you cannot keep confidentiality (such as in a case of child abuse), you should stop the mother and explain to her the limits of your confidentiality before you allow her to continue. Preserving confidentiality means, in addition, that you discuss data only

with NICHD project staff and that you conduct interviews only with families whom you are not otherwise acquainted.

C. Informing the Mother of Her Role

One of the most critical aspects to a successful interview is "training the respondent" (Fowler and Mangione, 1990). In other words, the interviewer should let the mother know what is expected of her in this situation. This is done by direct instruction at the beginning of the interview, as well as through modeling, careful listening, and by giving the mother feedback about the appropriateness of her responses throughout the interview. Keep in mind that being a respondent is hard work. The mother must listen carefully to the questions, give complete answers, and provide them in the form required. For example, the mother must learn to fit her answers into coded response categories when her most natural answer might be "it depends."

Immediately before beginning the interview questions, tell the mother what you will be doing and what you would like from her (see section on Administering the Fifteen Month Protocol). Also feel free during the course of the interview to "step out of the interview" to "train" the mother when necessary. Mothers are likely to feel most comfortable with the interview situation when they know what we want from them.

Positive reinforcement. When the mother responds appropriately to a question, provide positive reinforcement. This can take the form of a word or a gesture to let the mother

know that this is the type of behavior you expect. Phrases such as "Yes, I see," "Thanks," "Yes, that's what I meant," are all good examples of positive feedback. You can also reinforce her behavior by nodding, smiling and writing down her comments. How much feedback you use will depend on your respondent. Some learn their role quickly and require only periodic feedback, while others may need to be reinforced every time they make an appropriate response. Be extremely careful, however, not to reinforce certain types of answers. Remember that you are reinforcing answering behavior, not content.

Digressions. There are some behaviors that you want to be especially careful not to reinforce. An interview can continue for a very long time if you allow the respondent to tell you a story while answering each question. If the mother elaborates on something when you really only need a brief answer, say something polite like, "Yes, I see what you mean. I think I've got what I need here". A long digression can be halted by saying things such as "That's interesting. Let's finish the interview and then we can talk more about this later". Such a statement not only explains why you are there (i.e., to interview her), but also communicates to her that you are interested in her as a person. Since this isn't an open-ended interview (although some questions do allow for more open-ended responses), this probably won't be a big problem, but you don't want people to feel cut off. This must be handled delicately.

Interruptions. It is important that the mother hear the entire question and all the response categories before answering. Her answer may change after she has heard all the possible answer choices. If the mother tries to answer before you have had a chance to finish reading the question, gently let her know that she needs to hear the entire question before selecting an answer. You may also want to re-read the question to her.

If the mother starts giving you answers to questions that will be asked later on, let her know that you will be asking about that topic later. You may also want to let her know that you have to ask the questions in a certain order. It is better to stop her politely than to have her go through the information twice. You must try to maintain control over the administration of the interview.

D. Pacing

Pacing is one way in which the interviewer gains control over the interview situation. Establishing a good pace does not mean reading questions in a monotonous fashion. Questions should be read at an approximate rate of two words per second. Don't pause between every word, but between word phrases.

When the pacing of questions is slow and even, mothers answer more thoughtfully, and you won't have to repeat questions as often. The mother will set the pace of the interview from information and cues provided by you. A slower and more leisurely pace will allow you to work carefully and to follow

skip patterns and other interviewer instructions. Pace can also reduce tension for you and the mother. And, as mentioned earlier, slow and even pacing is important because an uneven reading of the question or response categories may bias the respondent by suggesting that some categories are more important than others.

E. Sharing Personal Information With the Mother

Even though you are trying to establish a conversational tone, you must avoid sharing personal information. By sharing such information, you may inadvertently establish certain response biases in the mother as she assesses what your values may be. The reliability and validity of the data depend upon the interviewer being able to establish an interpersonally neutral atmosphere. Making evaluative statements after the mother answers a particular question or sharing personal information with her are two major ways that an interviewer can introduce bias into the data collected.

F. When the Mother Reveals Personal Problems

Occasionally, in a mother's eagerness to talk, she makes an implied or direct appeal for help with her own personal problems. Sometimes, mothers can talk for so long about their problems that there may not be time to attend to the interview. (See earlier comments about digressions.) Interviewers should be careful about feeling that they must handle these problems or solve them

for the mother. You might say something like "I can understand your being upset (or concerned) about that. When we finish discussing the interview, we can talk about it more."

Researchers at each site should be relatively familiar with the services that are available to parents in their area. If a situation arises in which a mother requests information or some type of referral, you may say something like, "I can see that you would like help. I am not (trained) (in a position) to help you, but perhaps you would like me to talk with Dr.----, our Director, and s/he will know of someone that could be of help to you."

Immediately after the visit is completed, document the mother's concerns and requests on the Interviewer Report Form (see Appendix B) and discuss the situation with your Study Coordinator and/or Principle Investigator. Get back to the mother as promptly as possible with the appropriate information. If it seems appropriate to have your PI or SC speak with the mother, the Visitor should ask if the mother would like the Director to call.

Each site should keep a record of the kind of information distributed to a particular parent and what impact, if any, this had on the family's life, if known. (This can also be recorded on the Interviewer Report Form.)

III. MINIMIZING INTERVIEWER-RELATED ERROR

The proceeding section dealt with how to establish a friendly yet interpersonally neutral context for professionally

conducting the interview. The following points pertain to specific interviewing techniques which minimize interviewer-related error in data collection. These include specific standardized interviewing techniques as well as standard methods for handling difficulties that may arise during interviews. It is impossible to eliminate error entirely. However, by following the techniques outlined below as closely as possible, we will greatly minimize interviewer-related error.

A. Standardized Interviewing Techniques

1. Read Questions Exactly as Written

Reading the question exactly as written is critical to maintaining standardization across interviewers at all ten sites. If the wording of questions is changed by interviewers in even the slightest way, the researchers can never be entirely sure what question the mother was answering.

There are rare occasions, however, when exceptions are allowed. Sometimes reading the question exactly as worded will compromise rapport. When this happens, the interviewer may slightly rephrase the question as a confirmatory question so long as the same words are used as in the original question. For example, based on initial piloting with the One-Month protocol, several interviewers felt silly or awkward asking the mother, "Are you breast feeding Baby?," when the mother was actually breast feeding at that moment. The Interviewer may feel free in this situation to rephrase the question in a confirmatory manner.

For example, "And you are breast feeding Baby?" is perfectly acceptable in this situation.

While asking a confirmatory question may seem unnecessary in the breast feeding example, most other questions are not that clear cut. The HABIT of confirming ensures that no question is accidentally skipped.

Another occasion when a confirmatory question is allowed is when the observer already knows the answer. For example, it often occurs that the interviewer has already learned that the mother/father is self employed prior to the moment in the interview where this question is supposed to be asked. Following the guidelines above, there are two acceptable ways this situation can be handled. These are illustrated below.

Interviewer A said, "Sometimes we have a question which doesn't exactly fit the situation, but I need to ask you just for the record. Who is his employer?" She reports that so far, she has not had any mothers who seemed offended by even the most obvious questions. She feels that these types of shared awkward situations serve to build rapport, because it reminds the mother that both the interviewer and mother are engaged in a joint task.

Interviewer B, on the other hand, simply said, "And you are self employed?" Both approaches are considered acceptable. Which approach is selected depends on the interviewer's style, the mother, and the specific situation.

Interviewers will need to be as prudent as possible when deciding to use confirmatory questions because of the implication

that changing questions has for increasing interviewer-related error in the data.

2. Avoid Offering Interpretations of Questions, Words, or Phrases.

Unless every interviewer were to use exactly the same alternate phrasing or definitions, offering interpretation or definitions introduces unknown variability into the procedures. However, this is an ideal we want to strive for; in the interest of getting complete data and maintaining rapport, we may occasionally have to clarify a question or define a word when the mother is unfamiliar with the vocabulary. There are several situations when this may occur.

a. If a mother asks for clarification of a word or the meaning of a question and this has been defined in the Administration Manual, you may rephrase the question using the definition in the Administration Manual or give her the definition to help her answer the question. For example, if the mother asks, "What counts as separated?" in regard to marital status, you can tell her that it means that she is married but that she and her husband are not currently living together by choice. It is vitally important that interviewers brush up on these definitions by reviewing the Administration Manual on a regular basis.

b. If the mother asks for a definition of a particular word, the interviewer may give one in certain cases even if it is not defined in the Administration Manual. If the mother simply

does not know the meaning of a vocabulary word, you may offer her the definition. For example, if a mother does not know what a "tantrum" is, you can tell her that it means a fit of bad temper (dictionary definition).

An interviewer may NOT define the meaning of a word or phrase for a mother when the word is, or the phrase includes, an adjective or adverb. For example, if the mother asks how you would distinguish good or excellent health, you may not define this for her. Another example is if the mother tells you that she is usually very satisfied with her job but that occasionally she also experiences dissatisfaction and then asks, "Would that be somewhat satisfied?", you should not answer the question for her. In addition, you are not allowed to define terms like "Mostly false" or "has mixed feelings." A good rule of thumb is that if it is at all possible for mothers (and for you) to define the meaning of term differently based on differences in subjective experience, do not define the term. Instead, you may say something like the following: "In this situation we're interested in what this word means to you. Let me repeat the question...."

When you do define a word for the mother, keep your definitions short. In our experience, the more explaining you do, the more likely you are to get in over your head. If you choose to define a term for a mother, record the definition you used on the Questionnaire Log (if it is a questionnaire item) or on the Interviewer Report Form (if it is an interview question).

If you find that you frequently have to define the same word for different mothers, try to use the same definition. In addition, share this information with other interviewers at your site so that you can all try to be consistent in how you are defining terms.

3. Determine When a Response is Acceptable

As the interviewer, you will be the one to determine the acceptability of a given response. In order to make this judgment, you must be able to understand the mother's response. You must also be familiar enough with the Administration Manual to determine whether or not she answered the question sufficiently.

If the response is acceptable, record the information given and move on to the next question. A response is acceptable if it answers the question using the given response categories.

If the response is unacceptable, you must determine why. Sometimes this is because the mother answered in prose form, and did not use one of the precoded response categories. Or, the mother may not have heard the entire question or may not have understood what was being asked. If you think that this is the reason behind her unacceptable answer, re-read the question, emphasizing key words that convey the meaning.

Frequently, an answer is unacceptable because it does not fit into existing response categories. In this situation, the interviewer needs more or different information from the mother

and therefore, probing is required.

4. Always Probe Nondirectively

Probing means asking questions. Nondirective probing is asking questions in a way that does not prejudice the mother in any way but allows her to offer you an acceptable response.

Probing is used to re-focus the mother's attention on the available answer choices. For example, when the mother responds, "It depends" or "Somewhere between this category and this one," you need to preface your repeat of the question with a remark like, "Which comes closest..." or "In general..."

A. 4. 1. Probing closed questions. If the mother rephrases a response category, do not record the answer that you think comes the closest. Instead, ask her to select one by saying something like, "Which one of these answers comes closest to yours..." When you re-read the response categories, make sure that you read all the available choices. You do not want to narrow the choice for the mother by reading only the choices that are closest to her original statement.

A. 4. 2. Probing numerical questions. When probing for numerical responses, interviewers must take exceptional care not to lead respondents. Never ask a question that can be answered with a yes or no. Never suggest a particular range where the answer may fall. The simplest approach is to tell the mother that you need to get a specific value. If she says that she can only estimate, reassure her by stating something to the

effect of, "We would like it if you would make your very best estimate. Even though it may not be exactly right, no one is in a better position than you to make this estimate. Do the best you can."

If the mother offers two numerical answers which are both possible response categories, you can simply ask her, "Which answer comes closest to how you feel/your experiences, etc.?"

A. 4. 3. Probing open-ended questions. To probe responses to open-ended questions, the following three probes may be used. "How do you mean that?" is used when the respondent provides an unclear response. "Tell me more about that" should be used when the answer is incomplete. "Anything else?" should be asked even when a seemingly appropriate answer is given to make sure that additional points the respondent wants to make are heard. If the mother simply does not answer the question, repeat the question.

A. 4. 4. Probing "I don't know" responses. "I don't know" responses need to be probed. The first job of the interviewer is to determine the origin of the respondent's problem. The answer "I don't know" can indicate several things, and sometimes the best probe is the silent probe. If the mother appears never to have thought about the issue before, you may find simply waiting expectantly for an answer produces good results! Sometimes you may need to encourage her to think about it for a second, reminding her that she is uniquely qualified to provide information on this topic. You may want to say, "I wonder

if you could take a minute or two to think about it," or: "We are just interested in your opinion." If "I don't know" is given because the mother is unsure about the quality of the answer, remind her that there are no right or wrong answers to these questions and that we are interested in what she thinks.

If "I don't know" seems to reflect that the mother genuinely doesn't have an answer, it should be recorded as a "DK", and the response grid left blank. However, to be sure that this is the case, you need to probe all "don't knows" at least once. The purpose of a probe on a "don't know" answer is not to force the mother to answer if she doesn't know the answer, but to give her a chance to think about her response.

B. When the Mother Gives you Contradictory Information

If the mother gives you information which contradicts earlier answers she may have given you or information you gathered before or after the interview, you need to step out of the interview to ask the mother for clarification. For example, you might say, "I'm a little confused here. Earlier when we were discussing (fill in the blank) I recorded (blank). Am I missing something important here?" If the interview has already ended, the interviewers should feel free to bring out the interview forms and re-ask the appropriate questions. Before taking out the interview forms, the interviewer may want to first probe non-directively, (e.g. "Can you tell me more about that?") to get the "big" picture so as to be sure to cover all of the relevant

questions again. However, you may only ask the mother for clarification concerning factual information or confusing statements that she has made to you. If you think the mother's answer is inconsistent with something she has already communicated to you, you may re-read the question. However, in order not to compromise rapport or put an extra burden on the interviewer, interviewers may not re-read a question on those occasions when it might appear that the mother's answer is inconsistent with appearance (e.g. income is too little or too much given household appearance; mother says she is fine when she appears to be in considerable distress) or when the interviewer believes that the mother is, for whatever reason, not being truthful in answering the question. Such data errors will have to stand as reported by the mother.

C. When You Are Having Difficulties

Never use your own discretion in choosing answers for the mother. If the mother does not choose a category and your non-directive probing does not help, it is sometimes helpful to "re-train" the mother for her role as interviewee. Explain to her that this question has pre-determined categories and that you need her to give the answer which most accurately reflects her situation. Rapport, however, should not be compromised.

If you feel that it would be pushing the mother to repeat the question or to train her, treat her response as though it were to an open-ended question and write down verbatim what the

mother has said. After the visit is completed, you will want to discuss how to code her response with other interviewers, your study coordinator and your PI.

The following is a specific example of how to re-train the mother. It is based on an actual pilot mother.

I: (Question 18, Int 2a) "How would you describe your health compared with other women your age? Would ..."

S: "Good."

I: "This is one of those questions where I have a list of responses. I'd like to read you the list so that you can choose the one that fits your situation best."

S: "O.K."

I: "How would you describe your health compared with other women your age? Would you say your health is poor, fair, good, excellent?"

S: "Excellent."

D. When Mothers Have Negative Feelings About the Interview

Not all mothers will like every question, either in interview or written form, that we have to ask her. If a mother expresses negativity about a particular item, you should be accepting of her opinion, but do not convey the impression that you think the question is stupid, trivial or offensive. You may want to say something like, "Some questions may not seem relevant

to you or your lifestyle. Because this is a national study, we will be seeing many different types of families. For some families, this may be a relevant issue. Please answer the question as best as you can." If she seems offended by a question, supportively remind the mother that she can refuse to answer any question that she wishes to.

E. Exercises

The following exercises have been taken from the IHDP Phase II manual. Each exercise will emphasize a different type of interviewer skill. Try to answer each question listed as per the specifications of this manual. The answers follow.

Exercise 1:

Interviewer: Over the past few weeks, would you say that (child) is:

- 1) Not clinging, can easily be left with people (s)he knows
- 2) gets upset if away from you but gets over it, or
- 3) is very clinging; can't be left with others

Respondent: I don't know--she seems to act differently with different people. Usually, when I leave her with my mother, she's fine.

But sometimes when I leave her with the babysitter she gets really upset.

Interviewer:

Fill in response here:

Exercise 2:

Interviewer: For each statement I read, please tell me whether (child) acts this way rarely or never, sometimes, or almost always?

(Child) is worried about not getting enough.

Respondent: What do you mean by enough? Enough what? Toys, food, hugs?

Interviewer:

Fill in response here:

Exercise 3:

Interviewer: (Child) can't concentrate, can't pay attention for long.

Now in the last 6 months, is that statement very often true or often true, somewhat or sometimes true, or as far as you know, not true?

Respondent: Well normally she is pretty good about playing by herself for a long time. But in the last few days or so, she seems to get frustrated with all of her toys.

Interviewer:

Fill in response here:

Exercise 4:

Interviewer: A child's success at school depends on how much his mother taught him at home. Do you: strongly agree, agree, disagree, or strongly disagree?

Respondent: I don't know; none of my kids are in school yet, so I don't really know.

Interviewer:

List steps for probing this answer.

Answers to Interviewing Practice Exercises

Exercise 1:

The goal of this exercise is to provide practice in "probing" to get the respondent to answer with one of the existing categories. The respondent has provided an answer that boils down to "it depends". She has not answered the question. When you get an answer such as this one, re-read the question emphasizing the words that will help her arrive at an answer. In this case, begin your re-reading of the question with the phrase, "in general" and emphasize the phrase, "over the past four weeks" to indicate that she is to generalize over that period.

Exercise 2:

In this case, the respondent appears to understand the question, However, she wants clarification of a common word which can have several interpretations. You should respond "whatever 'enough' means to you".

Exercise 3:

The mother is unclear on the time frame that you want her to answer within. Stress that the information you want is what the child was usually like, or what was generally true, in the last 6 months.

Exercise 4:

There are several specific steps that you should go through before recording an answer of "I don't know". You should first use a silent probe, i.e., wait expectantly for an answer. This will give your respondent a chance to think about her answer. If she still does not answer, you may say: "I wonder if you could take a minute or two to think about it." or "We are just interested in your opinion." Then re-read the question, emphasizing key words or phrases. If the respondent is still unable to answer your question, record "don't know" by writing "DK" in the response category area, and then an "X" in the left margin to indicate that you "probed" her answer.

F. Putting it Together: A Friendly Context and a Professional Interview

It may seem that using the standardized interviewing techniques outlined above will be costly in terms of establishing rapport and a friendly tone to the visit. These techniques do not have to, and should not, interfere with our goal to provide a pleasant experience for the mother. The context in which the actual interview is embedded, i.e. what is said before, during and after the interview, is most critical in setting a relaxed and friendly atmosphere. Interviewers should also feel that they can "step out of" the interview at any time to maintain rapport. This is done by adapting to the mother's pace and the things (i.e. the child) competing for her attention. In addition, interviewers should feel free to "train" the mother whenever is appropriate by explaining to her exactly what you need from her.

While all questions should be read exactly as written, except where noted above, no two interviews will be exactly the same because the total context of the interview will be different in each case. For the purpose of minimizing interviewer-related error, all that is necessary is that the actual interview questions be read as written, with no or minimal interpretation, and that the interviewer always probes in a non-directive way and avoids all evaluative feedback. The goal for the interviewer is to become so familiar with these techniques that they become rote. In this way, attention can be devoted to listening to what the mother is saying and to responding to her concerns.

To establish and maintain rapport, it is also essential for the interviewer to be comfortable with administering the interview. If the wording of some questions seems awkward to you, practice saying these questions aloud until you feel comfortable with them.

Sometimes it is difficult because the interview itself is not perfect. It is impossible to anticipate the concerns of all of the families in our study. To some mothers, the interview will be more difficult to administer than to other mothers. At times, the interviewer may feel that the information recorded on the forms does not accurately reflect the mother's circumstances. There are many important and unique circumstances that confront some families that the interview will not tap. The interviewer's job is to help the mother provide the best information to the questions as they are given. Important information that is not included in the interview may be entered into the Interview Report Form. Also, remember that we will be updating our information every three months so don't worry if recent changes in family circumstances as reported in the interview do not fully reflect the family's more general situation. We will find this out in later assessments.

In conclusion, the most important job of the interviewer is to establish good rapport with the mother. In those cases where the mother does not appreciate your objectives as a researcher and is not responsive to your efforts to establish rapport while maintaining standardized interviewing techniques, bend the rules

as necessary to maintain rapport. (Indicate what you did on the Interviewer Report Form!) Through piloting we have discovered that most mothers are eager to cooperate with the interviewer and do their best job to be a "good" respondent.

IV. ADMINISTERING THE STANDARDIZED INTERVIEW

A. Purpose of This Section

This portion of the manual provides specific information about the questions included in the interview portion of the 15-month home visit. In addition, this section will serve as the archival description of the way in which interview data were collected.

It is vital to the success of the NICHD Study that the basic format and content of every 15-month interview be standardized. Please refer to other sections of the Operations Manual for the 15-Month Home Visit for specific instructions regarding the way the interview is to be conducted.

Questions should be addressed to Kaye Fendt at the Data Coordinating Center.

B. Format of the 15-Month Interview

Every interviewer should become thoroughly familiar with the format, layout, and questions of the 15-month interview. Because of the many different family situations we expect to encounter during this study, the questions have been written to try to cover a great variety of responses. It is not possible, however,

for the questions to suit every situation perfectly. At times the interviewer must adapt a question slightly so as not to appear insensitive to a mother. Whenever possible, alternate wording for these questions is provided within the text of the interview.

Within each section of the interview, there are a number of checkpoints when the interviewer must skip over particular questions or sets of questions because they are not relevant to a particular situation. It is important that each home visitor be completely at ease with these checkpoints so that the interview can proceed smoothly.

The conventions followed in this interview protocol are:

1. The directions to the interviewer that are not intended to be read to the mother are printed in ALL CAPITAL LETTERS. The questions and comments to be read to mothers are printed in upper and lower case type.
2. The interviewer is expected to continue to the next question unless instructed otherwise by a GO TO or checkpoint instruction.
3. Questions that must fit more than one situation are worded so that the choices between two wordings are in parentheses. Example: "How satisfied are you with your decision about (working/not being employed/going to school) right now?" The interviewer is expected to choose the correct wording for this particular situation, not read all options. This requires that

the interviewer have the questions clearly in mind and understand the different possible situations to which they refer, as well as being alert to the individual situation of the mother being interviewed.

4. Questions in which a person's name (or other specific information) is to be used indicate the missing information in capital letters, as, for example: "In MONTH when we last talked, you reported a problem with ILLNESS. Is that still a problem?" The question should be read as, "In May, when we last talked, you reported a problem with high blood pressure. Is that still a problem?"
5. There has been some confusion as to under what circumstances information in parentheses should be read to all mothers. After piloting, we have decided that information in parentheses will be read to all mothers UNLESS the information does not apply to that mother's situation. [For example, in Section 1, page 12, item 4: Unless the injury was an illness from a poisoning, this phrase is not read. For a second example, in Section 1, page 13, item 26: If the mother is the only one in the household, do not read the phrase in parentheses "(or anyone else in your (sic) holdhold)". For a third example, in Section 1 on page 15, item 33: If the mother did not previously report a health problem, do not read the word "(other)".]

1. Marking the Forms

The mark-sense forms used for the interview must be filled in carefully. Use a #2 pencil and be sure to blacken the entire space to indicate the mother's response. Whenever there are 2 columns of numbers, as for month and day, for example, mark both columns. If your response requires only one digit, mark 0 in the first column.

For example, to record a date of February 1991:

MONTH	YEAR
☐ 0	199 ☐ 0
1	☐ 1
2 ☐	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

The blanks above the columns are for your convenience in recording mothers' responses. Often it will be quicker to simply write in the response and then fill in the mark-sense spaces later. This is especially true for complex questions that have several sets of responses, such as the household information.

In response to some questions, a mother may give you additional information that is not coded but that you want to record in order to demonstrate that what she wants to tell you is important, and also to help build rapport with the mother. You can write such information on the forms as long as you do not

write over the mark-sense spaces. Be sure to keep your notes to the left side of the page.

Also, if it is not clear how to code a mother's answer, write all the relevant information on the interview, to the left of the mark-sense spaces. Before you turn in the interview, discuss the coding with your site coordinator or principal investigator.

C. Interview Script

The interview data forms contain only a few brief sentences to introduce or close sections. These were included to remind you to explain to the mother what is going to happen next. They do not have to be read exactly as they are written, but it is important to let mothers know what the general topic of your questions is going to be in advance. Interviewers can phrase these introductory and transition sentences in their own words. Once you begin the questions, however, they must be read exactly as they are written. The only exception to this rule is the occasional situation where the information requested is obvious or already known to the interviewer. In these cases, the interviewer may reword the question as a statement, confirming with the mother that the information obtained previously is accurate.

Before beginning the actual interview, it is important to give the mother some general information about the way you will be conducting the interview and what your expectations are. To

explain the purpose and format of the interview, say something like:

"During this part of today's visit, I'm going to ask you some questions about your experiences as a parent so far and get an update on your family. I'll ask you some of these questions as part of our interview, and I'll also have some brief questionnaires which I will ask you to fill out. Some of the things I'll be asking you are very much like what you have been asked before. That's because we want to know how things change or stay the same over time as your child grows. Please try to answer each question by telling me how you feel right now. This part should take no more than about an hour, OK?"

(If there are site-specific tasks, explain these here as well.)

To explain the interviewer's and mother's roles, say something like:

"In this part of our visit, I will read you a set of questions exactly as they are worded. This is so that every mother in the study is answering the same questions. I'll be asking you to answer two kinds of questions. In some cases, I'll ask you to answer in your own words. In other cases, I'll give you a list of answers and ask you to choose the one that fits best. If you have questions at any time during the interview, please be sure to ask me."

Mothers have different ways of responding to interview

questions. Some are very precise and specific, but others tend to give vague responses or answer in general ways that are not codeable. You can encourage mothers to be more specific by enlisting them as partners in the process of data collection. For example, if a mother responds to the question,

"How long have you been living with (husband/partner)?"

by saying

"Since 6 or 7 months ago."

you can say,

"I can only record one answer. Would you say it's 6 or 7 months ago?"

If the actual amount of time was somewhere in between, you can explain to the mother how we round up or down to come up with a single answer. The next time the mother responds with a range of numbers instead of a single answer, follow the same procedure. Usually after two reminders, mothers will understand the requirements of the interview and begin to give you codeable responses without prompting.

D. Face Sheet/Interview Record

The front three pages of the 15-month interview form are for use by the project staff at each site to help keep track of individual families. These pages will not be sent to the Data Coordinating Unit. The fourth page is the official record of the interview and should be included with materials sent to the Data Coordinating Unit.

In preparing for the interview, on the first face sheet, record the mother's and child's names, the family's address and phone number, and an alternate phone number in case no one is at home. Also record any special instructions about getting to the family's home (driving directions, parking, etc.). Information about travel time and mileage to the site are recorded during the visit so that future visitors will know how much travel time to plan. The name of the interviewer is also recorded.

Before leaving for the home visit, check to be sure you have all the materials needed for the interview, using the checklist on the face sheet.

On the second page of the interview forms, record the dates of previous contacts and the names of staff members who have visited with the mother. If the mother mentions someone or something that happened at a previous visit, it is helpful if you are able to identify the person who talked with the mother before.

In this interview you will only collect partner information about a live-in husband or partner. You will also update information for the child's father whether or not he has been involved with the mother or the child since the child's birth. Some mothers may find these questions unpleasant; however, for some mothers we have found that the child's father has reappeared after the child's first year and become an important person in the child's life. See the commentary on question 11 for more discussion of this situation. Fill in husband/partner

or child's father's name (if known) on page 2.

To prepare the My Child Care Questionnaire (Form 15K), use the 13-Month Telephone Interview forms, to identify the nonmaternal caregiver the project will be observing at the 15-month child care visit. If the father is the child care provider to be observed, do not complete this form. Enter that caregiver's first name and/or the center's initials (first name and initials only, to preserve confidentiality). Also enter the caregiver or center ID number onto the My Child Care form. Follow the instructions on page 2 for filling in information on the interview forms themselves. Use information from the six-month and 12-month contacts so you are up-to-date on the mother's situation and can conduct the interview with respect for the mother's individuality.

After the interview, once back at the project office, the three face sheets should be separated from the data portion of the interview form (follow the procedures set up at your site). The data will be checked and sent to the data center. The first face sheet is filed in the family's folder along with the Questionnaire Log Sheet and Interview Report Form, after discussing any problems or concerns with the Site Coordinator and/or Principal Investigator for your site. The second and third face sheets (interview scripts and instructions) are thrown away .

A cover sheet is attached to the front of Sections 1 and 2 of the interview forms. These are for identification of the

subject, the interviewer, and the date of the interview. Be sure these are completely filled out before sending interview data to the Data Coordinating Unit. It is wise not to fill out the date in advance of the interview, however, in case of last-minute cancellations.

If the mother is the person interviewed, code Rel code "0". If the mother does not live with the child full time, indicate this, as requested on the cover sheet of Section 1 by darkening "Not."

If the mother is not the person interviewed in the home at 15 months complete the Alternate Care Interview (form 15W). See chapter 15.5 for complete instructions.

E. Interview Section 1

Throughout this interview and manual, we refer to the reference child as CHILD, not BABY. If the mother has a new baby, be sure it is clear that we are asking about the reference child, not her new baby.

F. Months and dates: "Since we last talked"

Several questions request information from the mother about changes since we last talked with the mother. At the beginning of the interview, the interviewer should mention to the mother that we are updating information on changes in her family since we last talked to her on the telephone. The mother should be given the exact date of this telephone contact at this time, this

date may be repeated before each section where update information is requested. However, during the statement of the question, only the month of the last contact should be given. The exact date of the contact should be supplied again ONLY at the mother's request.

If there was no update with the mother at the 12 month visit, changes in the household and family status since the child's 12 month birthday (date of expected 12 month call) should be requested.

1. Part 1: Household Composition

Question 1

The purpose of this question is to track changes in the child's household composition and social network.

Before going to the home for the interview, you will have listed in Table 1 the names, the mother's description of the relationship, the sex, and the age of all the household members reported at the 12 month call. Do not enter the relationship code until after confirming the information with the mother at the 15 month visit.

Read question 1 to the mother. If no members of the household change, (change code 1 for all individuals listed), confirm with the mother her description of the household members' relationship to both the mother and the child. If there is a relationship change, cross out the written description, add the relationship description, and enter the appropriate new

relationship codes either at the moment of the interview or shortly after. Be especially careful if the mother has married since our last interview, as this may change the child's relationship to the household members as well. If a new baby is added to the household, round the baby's age to the closest whole number. If the baby is under 6 months of age, code 00 for baby's age. If the baby is 6 months or older, code "01" (one year) for baby's age. If there are no changes in the relationships, be sure to fill in the previous relationship codes as listed on the 12 month phone interview forms.

If an individual has moved out (change code 2), confirm with the mother the description of the household member's relationship to both mother and child at the 12 month call. Fill in the relationship codes (either now or later) from the 12 month phone interview, even if these have changed.

If there is a new household member (change code 3), record all necessary information. Write in the table the person's name, the mother's description of the relationship, and complete the codes for age, sex, and relationship.

If someone has moved out who is not listed on a previous interview form, record their name, relationship to the mother and child, and age, sex, and relationship codes. Enter change code 2.

If the child's father or another member of the household is temporarily away from home (for example, in military service), he or she should still be coded as part of the household (change

code 1). If this applies to the mother's husband/partner, complete question 2 and conduct the remainder of the interview considering him to live in the household.

Try to remember who lives in the household as you continue through the interview, because it will help guide whether to ask certain questions and the interpretation of some of the responses you receive.

Sometimes families move into another person's home. This would constitute a change in household composition, as the new household now includes those people living in the new location. Since every family's situation is very different, use your best judgement to differentiate temporary household changes (maybe only a week or two during renovations) which are not entered here as changes from permanent household changes (no longer paying rent at old location, eviction), which are entered here as changes.

Question 2

If the mother told you in going through the household chart that her husband/partner was temporarily away from home and she told you the reason, code the reason under Question 2. If you are not certain, find out the reason by asking, "And where is HUSBAND/PARTNER living now?" Code Employment if he is on a temporary job assignment away from home or if he has a job that takes him away from home from Monday through Friday or for a week or more at a time at least once a month.

Checkpoint 1: Part-time residents and Questions 3 & 4

Follow instructions for full-time residents here in order to record information on part-time residents.

The children listed here are those who stay in the child's household on a regular basis -- during the summer, for example, or every other weekend. This question is not intended to record information about people, such as grandparents, who are visiting for a week or two (even if they come every year about this time), or the brother-in-law who is sleeping on the couch this week after he and his wife have separated. The grandparents are always considered visitors, not members of the household, because they maintain their own residence elsewhere, but the brother-in-law should be considered to be a member of the household and recorded on the household chart as having moved in, if the mother believes that he will be living with them for at least a month.

For all children who come to stay in the household part of the time (every other weekend, or for 6 weeks during the summer, for example), record their first name, relationship to the child and relationship to the mother as she describes them to you. Also record their age and sex. Assign the relationship codes listed above the grid after the interview.

Checkpoint 2A: Status of Mother's Husband/Partner

From the information you collected in filling out the household chart, check off the appropriate box at Checkpoint 2, and move to the appropriate item on the interview.

Checkpoint 2B: Status of Child's Father

As we noted earlier, we are updating information for all

families on the child's father, when he is not the same.

Question 11 through 14

For some mothers, questions 11 to 15 may be very sensitive, and some mothers may feel they would rather not answer. Be sure to respect the mother's right not to answer our questions, and do not press the issue. Remember that these questions may be asked for confirmation, and you may choose to use confirming questions here in difficult situations. Mothers who have no contact with their child's father may still receive financial support, and/or they may still expect him to have an important role in their child's life later when the child gets older.

2. Part 2: Family Health

Question 15

Read the four choices and record mother's response. Do not try to interpret her answer for her, even if you think two runny noses are not a good reason to rate the child's health as "fair." You can add your notes about the mother's response, but you must code the answer she gives you.

Question 15 & 16

Amend to read: Since MONTH when we last spoke...

Question 17

Mother should have received a positive diagnosis of ear infection from a physician or health professional to code this as yes. Describe the medicine in her words. If she does not know the technical term for it, record what she does know (e.g., "some

kind of antibiotic," "pink liquid that CHILD took for 10 days").

Question 18

If the mother has not seen a doctor to certify that her child's ears are clear of fluid, or if the child is still being treated, record "No." The issue here is whether we can say for sure the child's ears are clear of fluid. If the child has had more than one infection since the 12-month call, record the answer for the most recent infection that required medicine.

Question 20 and 21

When you ask the mother how many times the child has been to the doctor, she will often begin to tell you the reasons. You can move immediately to Question 21 and walk her through the responses. To slow her down, giving you time to record, you can simply repeat what she is saying and confirm it. Your conversation might sound like this:

I: "How many times?"

M: "Well, we went in early March for shots and then he got a bad cough..."

I: "So he had a routine check up and immunizations in March?" (Mark Y for response 1.)

M: "Yes, and then he got sick."

I: "Was this a follow-up of an earlier problem or chronic condition?"

M: "No, this was the first time he'd been sick."

I: "So you took him to the doctor for a cough. What did the doctor say was wrong?" (Mark Y for response 3.)

M: "He had bronchitis."

I: "Was Kevin hospitalized for that?"

M: "No, but he was sick for a week."

I: "Has Kevin been to the doctor for anything else?"

M: "No, those are the only two times."

I: (Record 02 under Question 21.)

Repeating and confirming the information with the mother allows you to obtain accurate information in a conversational manner.

Response 22 (1) Routine Check-up or Immunizations refers to well-child visits or immunizations. These may be scheduled at different times by different pediatricians or clinics. We are not trying to determine which immunizations the child has received.

Question 22 (4) asks in greater detail about injuries. You can circle more than one response on 4b-4d (which you may need to do if the child has more than one injury since the 12-month call).

Question 23

We want to identify children who are disabled or have serious illnesses or conditions that will affect their development, that is, their ability to accomplish such developmental tasks as learning to talk, read, walk, etc. Do not record illnesses or conditions that do not restrict normal activities or interfere with development, no matter how serious or "of concern" they may be. Fewer than 10% of our children will have one or more restrictive conditions.

Sleep Problems: Questions 24-28

Read the entire question as written, including the information in the parentheses. The intent of questions 24 through 27 is to assess child sleep disturbances as indicators of possible emotional or general psychological distress or lapses of parenting that may affect the developing parent-child relationship. The intent of question 28 is to assess how much of a problem the child's awakenings have been for the mother or other family members.

Videotaped records show that babies and young children, like adults, generally wake up several times a night. However, these awakenings are generally not noticed by other family members and the child returns to sleep uneventfully. What we want to count are those awakenings of sleep disturbances for which the child does NOT return to sleep uneventfully. We want to count their frequency and their duration.

The person in most families likely to awaken to a young child's sleep disturbances is the mother. Therefore, we are asking the mother whether the child has awakened her during the night. She may not be aware of whether the child has awakened anyone else in the household. However, sometimes someone other than herself has been awakened by the child, and these other awakenings should also be counted.

At the 6 months' administration of these questions, a mother reported that her baby cried out in his sleep, waking the mother, but the baby was still asleep. Another case (that we can imagine

but that has not yet been reported to us) is one in which the baby may have awakened the husband or another family member, but not the mother. These circumstances are unusual, but you may want to be prepared for them, and the phrasings of the questions are designed to take this into consideration.

Read the information in the parentheses in question 24. In question 26, only read the information in parentheses if there are people other than the mother and child in the household.

For Question #27, we are only concerned with how long the baby's sleep was disturbed, not the sleep of the mother or of anyone else in the household. For example, some children may only wake up for a minute or so, and go right back to sleep, but the mother may make herself some tea, watch TV, or read a book, sometimes for hours. For that reason, in this question, we are only concerned with how much time the child is up. However, if the mother says that the baby was not awakened, then rephrase the question as "On average, for about how long would you say CHILD was crying in his sleep?", and record the number of minutes that the baby was crying in his sleep.

Only read the information in the parentheses if the mother says that the child did not awaken but was crying in his or her sleep.

Question #28. Here we are concerned with how much of a problem the child's sleep disturbance has been for the mother or other members of the household. Some people may wake up several times a night, but they may be able to easily return to sleep,

and they do not find the awakenings disturbing. Others, who may only be awakened once a week for a moment may find this very much of a problem. In still other cases, another member of the household and not the mother may be awakened, and this may also be a serious problem to the mother. Ask how much of a problem the child's sleep has been to the mother or any member of the household.

Question 29

Select breastfeeding or nursing to fit usual terminology in your region.

Mother's Health: Questions 31-34

These questions refer back to the previous home visit. At the 12-month call, the caller recorded mother's answer to the equivalent of q. 31, BUT the caller did not record and code the answers to the equivalent of qs. 32-34. The mother may have volunteered this information, so that the interviewer may know more about her health at 12-months, but the computer (and, therefore, anyone depending on the computer to tell them) does not have a record of this. Therefore, sq. 32-34 refer back to the previous home visit, so that our computer records will be complete. Obviously, if the interviewer knows some of this information already, he/she can confirm that, and check for other problems that he/she may not know about.

Questions 32-34 should be read with the month of the 6 month visit or the month in which the 6 month visit would have occurred. In the "set-up" of this section, the interviewers can

say something like: These next questions refer back to May 10 (using exact date), when we last visited you (or, if no visit, when CHILD was 6 months old.)

Question 31

Read the four choices to the mother and get her description of her overall health. Do not try to interpret her answer, even if you think differently than she does.

If mother begins talking about her health problems, move through Questions 32, 33, and 34, getting specific responses as quickly as you can without being rude. Do give the troubled mother a chance to complain or explain, but do not encourage long descriptions of health problems. Often, a sympathetic, "I'm sorry to hear that," followed immediately by the next question, will get the conversation back on track.

Do record health problems described by the mother as these may be important in her ability to (a) work and (b) provide care for her child. Also, it will help build rapport with the mother when next time she is called, you ask specific questions about her health.

Question 32

Follow up on the mother's previous description of any health problems that a reasonable person might expect to have continued. For example do not ask about colds or flus, but do ask about backaches or diabetes. Not only will this help build your relationship with the mother, but it will provide an indication

of the extent of the mother's health problems and how they may affect her ability to work.

Question 33 and 34

If mother indicates any new health problem, get her description of the problem and record what she says. Much of this specific information is primarily useful to your site in becoming acquainted with the family and keeping track of events that may influence participation in the study.

If the existence of a health problem does not get mentioned until Question 34, and you are unsure whether this is a health problem that should be recorded in question 33, ask, "Would you say _____ was a health problem for you?" If the answer is yes, then record this information and Yes under Question 33.

If you know about a health problem before you get to Question 34, simply ask, "Have you seen a doctor or other medical professional since MONTH?"

Question 35

Ask this question only about a live-in husband/partner.

As with the earlier general health questions, read all the responses and record the mother's choice. Do not interpret her response.

Question 36 through 40

The purpose of these questions is to identify any important events impinging on the mother or the family and give the mother a chance to talk about important events that are not covered

elsewhere in the interview.

Question 37

Do not read the information in parentheses, but do mark a "yes" answer here if the mother mentions alcoholism or addictions. If you ask this question and the mother answers "No" after she has told you earlier that a relative or close friend has alcoholism or addiction problems, you may ask about this situation using confirmation. You may re-enter the data as necessary.

Remember to ask "Anything else?" after the mother reports problems of any kind. It may be that with the report of one problem, she forgets to mention other, more or equally serious problems.

When mothers report any of these events, interviewers should not make any comment in response unless the mother herself shows distress or sadness. For example, death of a very ill or very unloved relative could be a positive event when viewed through the mother's eyes. Only when the mother expresses clear sadness or grief may interviewers express sympathy. The interviewers should limit any statement to a sentence and then move on (with a reasonable pause as necessary) to the next item.

Interviewers are also cautioned against responding positively to what appear to be positive events reported by the mothers. We do not want to appear to be encouraging mothers to be reporting positive events to us. Rather, all events, positive

and neutral and negative, should be responded to neutrally by the interviewer unless the mother expresses distress.

Question 40

In this question, we only ask about the mother's moves. A move is a change in location of household. A new apartment even at the same address is a "move."

F. Interview Section 2

1. Part 3: Mother's Employment and School

Remember, mothers who are still on maternity leave are considered, for purposes of this interview, to be "not working for pay". Sometimes a mother who is on leave from her job performs activities related to her job for which she receives no additional pay above and beyond the compensation during her leave. According to our definition, this mother, too, is not working for pay.

Question 1, 2, and 3

The Work Update Chart allows you to record a lot of information in a small amount of space. Before going on the visit, you will fill out the Work Update Section for Primary and Secondary Jobs if the mother was working for pay at 12 months. You will include her position title and employer. A change code must be entered for each job recorded. For mothers who were not working for pay at 12 months, these sections are left blank prior to the visit.

Question 1

For mothers who were not working for pay at the 12 month call, you will begin with Question 1. If the mother has begun a new job; that is, she is currently at a job which she began after the 12 month call, fill in this information in the Work Update under Primary and Secondary Job Info. using "NEW JOB INSTRUCTIONS" below. [Do not record any job information for jobs she may have both started and ended between the 12 month call and 15 month visit.] You will record information for no more than two new jobs. If the mother works for pay at two jobs, you need to determine which job is primary and which job is secondary. The primary job is the one the mother works at for the most hours at the 12 month call. If the mother has two jobs and works the same number of hours at each, the primary job is the one with the higher salary.

NEW JOB INSTRUCTIONS. To complete the work update for a new job(s), you will ask the following prompts. "What is your position title?" If the job title is not clear to you, ask "What are your most important activities or duties?" and record what the mother says. ; Then ask, "What kind of (business/organization) is that?" and record the type of product manufactured, the primary activity of the organization, or the nature of the business.

Use the occupation coding definitions (Chapter 7, appendix A) to choose an occupation category. Get as much information from the mother as you need to accurately code her occupation.

For example, if you have learned that the mother works as a nurse, you need to find out if she is an RN (coded under Professional) or an LPN (coded under Technicians). If you have questions about the proper code, talk to your site coordinator or principal investigator.

Then ask, "When did you start working at this job?" To get income information, ask, "From either annual or monthly categories choose the one that best (represents/represented) how much you (earn/earned." Add, ["Is this before or after taxes?" and hours ["How many hours a week (are/were) you working for pay?"

Question 2

If a mother was working at the 12 month call, begin with Question 2 and update the information on jobs you listed under "Primary and Secondary Job Information." Update for the primary job first and then ask about the secondary job.

--- For any job in which there was no change (code=1), update the income information by asking, "From either the annual or monthly categories, choose the one that best (represents/represented) how much you (earn/earned." Add, "Is this before or after taxes" and "How many hours a week (are/were) you working for pay?"

--- If the mother has stopped working for pay at this job permanently, fill in Change Code 3, and ask, "When did you stop this job?"

--- If a mother says that she is temporarily away from her job on some type of leave other than being on vacation (e.g. before or after the birth of another baby, long-term disability, leave of absence, a sabbatical, etc.), confirm with the mother that she is currently not working any number of hours for pay either inside or outside of the home. If the mother is working any hours for pay (that is, above and beyond any leave salary benefits), we consider her still employed. For purposes of our study, the most important characteristic that defines a mother as on being leave, is that she return to work. If the mother's leave time arrangements are more informal, enter change code 3 (for job stopped) and follow the appropriate skip patterns. Remember to sensitively remind the mother that our definition of not working may be a bit different from hers and that some questions may seem a bit awkward (e.g. Why did you stop working at this job?).

If the mother fits our definition for being on leave, fill in change code 6 and ask, "When did you go on leave from your job?". Record this date under "Ending Date". Throughout the rest of employment update section, this mother is considered not working.

--- If a mother is on a regular, paid or unpaid vacation of 1 month or less, we treat her as still currently employed. In the Maternal Employment Update, we enter change code 1 and record her usual number of hour employed/week since our last contact. We also record her salary as she gives it to us. For the rest of

the employment questions, she is considered employed. NOTE: We only consider the mother as being on official vacation time if she and her employer have an agreed upon date for her return. If she is just more informally taking time off from her job, count the mother as having stopped her employment (change code 3).

If the mother is on a paid or unpaid vacation for longer than 1 month but will resume employment before our next contact with her (phone or visit), we enter a change code 1, record "00" for number of hour employed per week, and record her income. The rest of the questions pertaining to her employment can be asked in reference to when she is not on vacation.

If the mother says she is on vacation for a period extending beyond our next contact with her and/or if there is question about whether she will return to her job after an extended vacation, treat the mother as having ended her job (change code 3). Follow the skip pattern appropriate to her having ended her job but be sensitive to the fact that she might still consider herself an employed mother.

--- If the mother has experienced a change in her job title or position, but her employer has not changed, fill in change code 2. Update the mother's new information by asking "What is your position title?" If the job title is not clear, then ask "What are your most important activities or duties?" and record what the mother says. Now choose a new occupation coding category are in Chapter 7, Appendix A. Get as much information from the mother as you need to accurately code her new occupation

rating. For example, if the mother works as a nurse, you need to find out if she is an RN (Coded under Professional) or an LPN (coded under Technicians). If you have questions about the proper code, ask your SC or PI. Next, ask the mother, "When did you start this job?" Be sure to record the date she started her new position. Finally, update her income by asking, "From either the annual or monthly categories, choose the one that best (represents/represented) how much you (earn/earned)." Add, "Is this before or after taxes?" and "How many hours a week (are/were) you working for pay?"

The NA code under Job 2 indicates there is only 1 job being recorded.

Question 3

If the mother has begun a new job since the 12 month call, you will record this information on the Work Update under the "New Job Information". following the instructions above called "NEW JOB INSTRUCTIONS" to complete the Work Update grid. Do not get information on jobs that the mother both started and ended between the 12 month call and the 15 month visit.

NOTE: Throughout this section, a mother is considered now working for pay if she is currently going to work at a paid job. This job may take place in her own home. Mothers who are on leave or doing volunteer work or working in exchange for services are not considered, for our purposes, to be now working for pay. Record job information even if the mother works only a few hours

a week.

In unusual cases, the mother may be currently working at three (or more) jobs, but there is only space to enter information from two jobs. Since we care most about the total number of hours that the mother works and her income, we will be combining information from all jobs in the Secondary Job information. Report the occupation code for the job with the higher occupation code. Enter the total salary and total hours per week from all the secondary jobs. For all subsequent questions about the mother's employment, the mother may respond for all jobs combined.

If the mother works every other week, or some non weekly schedule, average the number of hours worked per week over a one month period to get an estimate of "hours per week".

Question 4

Interviewers may want to "re-set" the stage before asking question 4 on page 6 of the interview.

Count only hours at home for which she is paid, and, if she is a salaried professional, hours that are directly related to her paid employment. If the number of hours varies, ask for the "most typical situation" in the mother's opinion.

Question 5

If mother's work falls within one of the time periods listed in Question 5, record that period even if she does not work the whole time. For example, if she works from 1 to 5 p.m., record

(1) Daytime. If she regularly works hours that overlap the intervals listed, record both times. For example, if she works a 12-hour nursing shift from 11 a.m. to 11 p.m., record both (1) Daytime and (2) Evenings.

Similarly, if a mother works days and evenings on a regular basis because of having two jobs, record both. If a mother's hours change from day to day on a regular basis (for example, she works 1-5 p.m. on Mondays, Wednesdays and Fridays, and 1-9 p.m. on Tuesdays and Thursdays) record both (1) Daytime and (2) Evenings. Category (4) Times Vary should be used only when the mother's hours are different from week to week: mother works days one week and evenings the next.

Question 8

Hand Card 8 to mother and ask her to choose the most important reason. Record Other only if none of the choices fit her situation.

Mother's health includes her mental health. For example, if mother says she experienced emotional tension or exhaustion, code 4, mother's health. Note that you do not have to ask the mother if she considers "emotional tension" to be a "mother's health" reason; the study is defining it that way.

Child's health includes behavioral reactions of the child in child care, such as the mother's belief that the child was having stomach distress, sleep problems, or eating problems.

Childcare problems are the "external" problems of finding appropriate and affordable child care. They may include lack of

available care, losing a care provider, care that is too expensive or inconvenient, care that is unreliable or of poor quality, distrust of sitters, and the like.

Work-family demands in conflict includes employer inflexibility about the mother's need to take time off for family or personal reasons, or the mother's own feelings of not being able to cope with competing demands.

If the mother says something like she just changed her mind, or she thought she would be able to handle working and caring for her child but found out she couldn't, ask her to choose which of the listed reasons was the most important in her decision.

Question 10

"Going to school" is defined as enrolled in an educational program that normally leads to a degree, certificate, diploma, or the attainment of job-related skills. Correspondence courses may count here. Taking an evening course just for the fun of it does not count as going to school, nor does taking a parenting class offered by the local hospital. On the other hand, if the mother is taking an evening course on computers because she is planning to start a word processing business at home, then it should be recorded. Similarly, if the mother is enrolled in something like 6 credit hours at the local community college she should be counted as attending school even if she is not officially in a degree program.

Knowing what kind of school the mother is or was attending is important for later questions and also for building and

maintaining rapport with the mother. Although this information will not be coded into the database, it will be important for you to know in future conversations with the mother.

Question 13

The intent of this question is to find out how much time the mother spends doing school work -- time in class plus time spent on school-related work. As a general rule, use the following coding rules for counting hours in school. For high school or vocational school where people enter a building and attend classes for a portion of each day, count the number of actual school hours (e.g., 8:30 to 3:30 for five days a week would count as 35 hours). For community college, college, or graduate school, count the number of credit hours in which people are enrolled multiplied by 3 to get an index of involvement with school (e.g., a student enrolled in 12 hours -- which is considered a full-time load -- would be recorded as going to school for 36 hours; a student enrolled for one course of 3 hours credit would be recorded as going to school for 9 hours). Although different types of schools will vary somewhat in their time requirements, these calculations will provide a general index of time spent.

Question 14

If mother's school hours fall within one of the time periods listed in Question 13, record that period even if she does not go to school the whole time. For example, if she attends school from 1 to 5 p.m., record both (1) Daytime. If she regularly

attends school during hours that overlap the intervals listed, record both times. For example, if she is in school from noon to 7 p.m., record both (1) Daytime and (2) Evening. If the mother is in school during both daytime and evening hours regularly during the same week but on different days, record both (1) Daytime and (2) Evening. Use (4) Times vary only for situations where the mother goes to school days one week (for one month) and evenings another.

Question 16

Hand Card 9 to mother and ask her to choose the most important reason. Record Other only if none of the choices fit her situation. See question 8 above for explanations of the reasons.

2. Part 4: Husband-Partner Employment and School

We are limiting the information we gather on husband/partner employment and school to that which we consider most important to our research questions: whether he is employed or in school, how much he earns, and how many hours he spends at work or in school.

In this section, we are collecting information about the husband's/ partner's current job situation, as of the day of the interview. We will update this information every 3 months during the course of the study.

3. Part 5: Feelings and Attitudes about Employment

Questions 23 and 24

Give the mother card (3) while you read the question. Choose the wording (working, not being employed, or going to school) that fits the mother's situation. (If the mother is on leave, you may ask how satisfied she is with the decision to be "on leave" right now.)

Question 24

Give card (4) to mother and ask her to choose the one that reflects how she feels right now. Do not fill in more than one response. If the mother gives you more than one, ask her which one would be "most ideal" for her right now.

Question 26 through 28

Question 26 is for mothers not now working for pay 10 hours or more a week. Question 27 is for mothers who are now working for pay 10 or more hours per week, and Questions 28 for mothers who are in school 10 hours or more a week. If mothers are both working and in school, ask which they consider more important to them right now (Checkpoint 3) and ask those questions.

For mothers who are on leave or are on vacation, you will need to probe for more information to determine the appropriate form to administer. In both cases, determine whether the mother will be returning to employment for 10 hours per week or more after the leave or vacation time. If she is returning for 10 hours or more per week, administer Question 26. If she is returning for less than 10 hours per week, administer Question 27.

Note that each form includes a question (c) related to the mother's husband/partner, and these should be omitted by the interviewer and scored NA if mother has no live-in husband/partner.

Mothers who are working fewer than 10 hours may object to being classified as "not working". You can show respect for their individual situation by slightly rewording Question 26 to read: *"People choose to limit employment during their child's early years for different reasons. I'm going to read several reasons that mothers have given us for their decision to limit their employment. Some of these statements will fit your situation and others will not."* The stem for the question should then read: "I am limiting my employment right now because:" Those mothers who are working only a few hours a week can then indicate reasons they feel are not relevant to them by responding with 1) Definitely false.

A similar situation arises when a mother has left her job and is working at home because she wants to be with her family. She is still employed, as long as she is working for pay. However, if you insert the sentence, "Some of these statements will fit your situation and others will not," you will indicate to mothers that they can respond to those statements which do not fit their situation with 1) Definitely False.

When you are probing for Other responses, if the mother gives you more than one, ask her which was the most influential and record only this reason.

This is a complicated question. If the mother is not sure

what you are asking and asks for clarification, be sure to read the entire question again.

G. Interview Section 3 (Giving the mother the MacArthur and Collecting the Ear Infection data, and permission forms, debriefing, and Updating Addresses)

1. The MacArthur Questionnaire. After all standardized questionnaires are complete, you should hand the mother the MacArthur Inventory of Language Development. Read the following instructions:

"We are asking all mothers to complete this form and to return it when you visit our playroom. The form is called the MacArthur Communicative Development Inventory for Infants. This inventory was designed to be used for children who are both younger and older than your child. You should not expect your child to understand the meaning of all the words we ask about. The other thing you should know is that there is great variation in early language development. It is perfectly normal for a 15-month-old to have only one or two spoken words.

This inventory should take you about 45 minutes to complete. If you can, try to complete it in one sitting. Make sure you record the date you completed it at the top of the first page. We want you to fill it out just before you visit our playroom if possible.

We have one more request. This form will be scored by a computer, so please do not fold it."

If the mother has already had her lab visit, she should be

given a stamped and addressed 10" by 13" envelope along with the inventory and asked to mail it back to the office within a week. A person designated by the site should check to make sure that the Inventory is received in 7 days. If not, a follow-up phone call should be made.

For non-reading mothers, the inventory can be administered at the end of the home visit, at the end of the lab visit, at an additional home or lab visit, or by telephone, as needed.

2. The Ear Infection Data Collection Procedures.

A. Background Information

Otitis media is the medical term used to refer to a collection of fluid in the middle ear. Children who have ear infections have this fluid which may or may not continue to be present beyond the infection itself. During episodes of ear infection the presence of fluid in the middle ear may cause some depression of hearing level. Frequent episodes of otitis media with hearing loss may result in a delay in some aspects of speech and language development. Therefore, it is important to collect information about this infection history from as many children as possible.

Feagans (personal communication) claims that maternal report is an unreliable measure of ear infection and otitis media history. Regular physician checkups and audiometric testing are optimal but cost prohibitive. Thus, we have chosen an alternative means for gathering this important data. We will be obtaining permission from the mothers to contact their child's

medical provider(s) to ask for information about ear and upper respiratory infections only. Once permission is obtained, we will be mailing a physician form to each doctor requesting a medical history of upper respiratory infection, ear infection, and otitis media from birth until the present time (15 months). Later at 24 months, a second identical form will be sent for updated records.

After the MacArthur Language Inventory has been given to the mother, the experimenter should explain to the mother about the ear and upper respiratory infection data collection and ask her to fill out the permission form. The script for giving this information is as follows.

B. Script for requesting the mother's permission to contact CHILD'S medical provider(s).

After the MacArthur Language Inventory, the experimenter says the following:

"The last form we would like you to fill out today concerns your child's health records. As you know throughout the study, we have been asking questions about CHILD's health. Most of these questions you as the parent can answer directly. However, there is one area having to do with ear infections and upper respiratory infections about which we would like to get additional information from your child's medical providers.

Let me take a few moments to explain why we would like to contact your child's medical providers directly. We are particularly interested in the ear and respiratory infection

histories of all of the children in the study because these infections are so common among children in the preschool years. You have already answered many questions about your child's health. We would also like to contact your child's medical providers, if we can, because it is possible that they may have other information that could be of use to us concerning your child's ear infections and upper respiratory infections.

Therefore, we would like your permission to contact your child's medical providers to give us whatever information they have about your child's history of ear infections and upper respiratory infections. Specifically, we will be requesting information about the number of occurrences of ear infections and upper respiratory infections and the presence of fluid in the ear during and following the time of infection. This is the only information we will be asking the doctor or clinic to provide.

Your participation in this data collection is completely voluntary. If you are willing to have us contact your Child's medical providers, please take a moment to fill out these forms. Thank you."

Hand mother Form 15L-a Physician Contact Form to get her written permission and the name, address and phone number of child's medical providers.

C. Trouble shooting suggestions

What if the mother has the following reservations about your contacting her medical provider(s) for the ear and upper respiratory infection information?

- a. Mother is still concerned about what you will ask the medical provider.

Assure her again that ONLY information on ear and upper respiratory information will be gathered.

- b. Mother is concerned about having taken the child to several medical providers.

Assure her that this is common practice.

- c. Mother is concerned about not having taken the child to a medical provider when the child had an ear or upper respiratory infections and/or for follow up visits.

Tell her that this is common and she should not feel negligent in any way.

- d. Mother is concerned that the child has had recurrent ear and/or upper respiratory infections.

Assure her that recurrent ear and upper respiratory infections are common in children.

- e. After Mother gives information about child's medical providers and is asked if there are any other medical providers to whom she has taken her child, she reports there are but they are not relevant since the child was seen there for either well visits or shots or emergency treatment of things unrelated to ear infection and upper respiratory infection.

You do not have to press to get these additional

names and addresses.

- f. Mother has moved from one section of the city to another or from one city to another.

Ask for the names of all prior medical providers to which the child was taken.

- g. Mother says child has never had ear infections. Tell her we are also interested in upper respiratory infections, such as sore throats and colds.

What if the mother has agreed to allow you to contact the medical providers, but does not know the providers' addresses and telephone numbers and asks to mail in the form?

Suggest that you look up the phone numbers and addresses together, if possible. (It is possible that some mothers may have difficulty looking for this kind of information.) If the mother still seems reticent or it is not possible to look up the numbers, take the information offered and look up the phone numbers and addresses back at the site. Call the medical providers for the full address(es) back at the site, if necessary.

What if the mother asks if she can get some feedback on what the medical provider(s) report?

Tell her that the medical provider(s) must be assured that the information will be kept confidential in order for them to agree to release it. Suggest that if she wants to know more

about what the medical provider(s) have found, she may want to call her medical provider(s) directly.

What if the mother says she does not have a medical provider and asks for a referral?

Sites may want to give the mother the name of a referral source from whom she can get the name of a medical provider.

What if the mother wants to know more about how this information is going to be used?

Suggest that if she still has questions, she can contact the Principal Investigator at your site.

D. Ear Infection Post Visit Follow-up

1. Enter the child's name and ID number, all medical providers' names and telephone numbers onto the Ear Infection Follow-up form (15L-b). This form will be used to record the date the form is mailed, the date a follow-up call is made (if necessary) and the date the form is returned. The Ear Infection follow-up Form must be kept in an accessible file for easy retrieval.

2. Prepare a letter to the medical provider with the appropriate information as indicated in the sample Letter to Physician. Fill in the child's name, birthdate, and subject number on the Physician Health Form Instruction sheet and data sheets. On the page 1, item #3 of form 15 L cross out the months for which information is not being collected. Thus, if this form is being used at the 15 month visit, cross out 9 months and 12 months. Make copies of the parent's permission form. Keep the

original in the Ear Infection File and send out the copy(s) to the medical providers.

3. If your site is in a small community in which a few doctors or clinics are going to be receiving a large number of these forms, it might be helpful to call and enlist the doctors' participation prior to mailing the forms. It is a good idea to explain to the doctors that this is an NICHD Study of Early Child Care and that their cooperation will enable us to learn more about the incidence and possible effects of Otitis Media in children during the preschool years.

4. Mail the letter to the Physician, the Physician Health Form instruction sheet, one copy of page 1 and 10 copies of page 2 of form 15L, and a copy of the parent's permission form to each medical provider listed. Record the date sent on the Ear Infection Follow-up forms. (Each site can determine the most efficient method of mailing the physicians' letters and forms. It may be that doing one mailing each week will be more efficient than sending them out after each home visit.)

5. Forms returned within two weeks should be dated and recorded on the Ear Infection Follow-up form.

6. Forms not returned by the end of two weeks require a follow-up phone call to the medical provider(s). It is not necessary to speak to the doctor personally since in most instances it is the nurse or receptionist who fills out the form. Indicate that the child for whom the form was sent is part of an NICHD Study of Early Child Care and that the information we have

requested will provide us with important data about the incidence of ear infections, upper respiratory infections, and otitis media in the preschool population. Ask if the form has been received, and if not, offer to send them another one. If the form has been received, ask when you could expect it to be returned. The date of the follow-up call should be recorded on the Ear Infection Follow-up form. Receipt of forms following this call should be recorded as above.

7. If the physician or clinic does not respond after the follow-up call, the ear infection/respiratory infection data will simply not be collected. You do not have to make a second call, unless the physician (her receptionist, nurse, etc.) and or clinic could not be reached. Do not leave a message on the answering machine.

8. In the event that the physician mails a copy of the whole chart instead of filling out the data sheets as requested, someone at the site should transfer the information to the data sheets.

9. Upon receipt, a copy should be made of all Physician Health form data sheets. The original Scantron form(s) should be sent to the data center and the copy(s) kept in the subject's file.

3. Debriefing

After administering the Otitis Media forms, give the mother a chance to tell you anything that is important to her that you

haven't asked, and to ask you any questions about the visit or the study.

This is necessary to give the mother a sense that she is an important part of the research process and to give her the chance to express any adverse feelings she may have had about the interview. The interviewer needs to be sensitive to any negative affect in the mother and needs to give the mother a chance to share her feelings. If the mother asks questions about the research hypotheses, try paraphrasing the information in the consent form and two-week phone call.

4. Address/Phone Number Updates

Finally, the interviewer must update addresses and phone numbers. Then check to be sure the family does not have plans to move. If there is a chance the family might move in the next few months but no definite address or phone number is available, have a card or letterhead with the project address and phone number printed on it, and ask the mother to contact your office if they do decide to move.

It is very useful to have the work addresses and phone numbers of both mother and father as possible back-up contacts. Also, be sure to ask if it is OK to call the mother or father at work.

It is vital to have the names, addresses, and telephone numbers of one or two people who will know where the family is. Sometimes you may feel you are pressing the mother a bit to get these back-up contacts. We cannot overemphasize how important it

is to have at least one other person who can be called or contacted if the family suddenly disappears with an unlisted phone number or disconnected phone. Therefore, it is worth "pushing" -- politely, of course -- and perhaps explaining that this is a very important study and we want to be sure that the family has an opportunity to be included in all phases of it.

Conclude the interview portion of the visit by saying something like, *"That's all the questions I have for this visit. Thank you very much for your help."*

V. ADMINISTERING THE STANDARDIZED QUESTIONNAIRES

A. General Questionnaire Scripts and Concerns

The printed forms contain two brief introductory sentences to remind you to explain to the mother what is happening next. You do not have to say these two sentences exactly. So when you reach the first questionnaire section, you say something like:

"Now I have some questionnaires for you to fill out yourself. You may remember seeing some of these questionnaires before. I want you to fill these out thinking about what is happening right now or how you feel about things at the present time. If you have problems with any of the questions, please let me know".

Be sure to let mothers know that they should ask if they do not know what they are supposed to do. Also point out to the mother that she will blacken in her answer as completely as possible in the appropriate space with the pencil which you will be handing her at this point.

Give the questionnaires to the mother one at a time using some hard writing surface (not a clip board, it wrinkles the Scantron forms). The printed forms contain brief instructions for each questionnaire which you can say out loud (see specific administration information for each questionnaire). These instructions should be read exactly as they are written. However, encourage the mother to carefully read the instructions for herself.

When the mother finishes each questionnaire merely say "thank you," not "that's great" or even "fine". It is common for people to worry that they are doing questionnaires "right" (more about that later), so do not use any evaluative words that make them feel that you are judging whether they did it "right" or not. Also, maintain some physical distance if possible so that the mother does not feel that you are looking over her shoulder. You may want to inconspicuously monitor her just at the first to see that she is starting off correctly.

As you take up the first questionnaire, say something to the mother like *"Do you mind if I look quickly at these when you are finished just to see that all the spaces got filled in?"* The mother will probably say that is ok, then just quickly scan for blanks. Ask the mother to fill them in if you find missing spaces. If the mother says that she does not want to answer that question, say "fine" and record on the questionnaire log that she refused to answer an item. If she says that she didn't know how to answer an item, ask her for her

best answer. If the problem is that she does not understand a word, you can define a word for her (more about that later). If the mother does not want you to scan the questionnaires, ask her if she will quickly scan it for missing items for you. When this is complete (whether you scan it or the mother scans it), place the questionnaire in an envelope so that it is clear to the mother that her answers are now out of sight. If you find missing data when you get back to the office that you did not detect, call the mother as soon as possible and get the missing response by phone.

If it appears that the mother cannot read, or if she is taking a very long time (very poor reading skills), you may offer to help her read. Do this only when you really feel that it is necessary. You can say something like, *"We would like you to fill these out yourself, but if there's any difficulty, I will be glad to read the questions to you. I'll give you a moment to look at the forms and see what you think."* For this purpose, always take an extra set of the questionnaire forms. Read them to the mother, help her keep track of where you are on the form if necessary, but if at all possible, let her mark her own copy of the form so that her answers are given as confidentially as possible.

If the mother asks you to read the questions to her, and you know she can read, stress to her the importance of administering these questions in the same way to everyone and that we really need her to read the questionnaires.

As you check over each questionnaire, you will mark on a Questionnaire Log whether blank responses are refused information or if you were unable to check her responses on a particular questionnaire (in which case, it may just be missing data). This log will also have a place for you to indicate whether you had to read any of the information to the mother and whether you suspect that some of the information may be unreliable (e.g. the mother seemed harried and just whizzed through the questionnaire, she didn't seem to understand a questionnaire or certain items well, she couldn't attend well enough to respond, she expressed resistance, kept asking when this would be over, seemed tired of doing the questionnaires and was just trying to get through them and so on).

B. Encountering Unusual Circumstances

Several unusual situations have arisen in piloting.

Following are some ideas for dealing with them.

1. The mother asks someone else in the home to help with the questionnaire answers (her husband, her mother, a friend):

Politely make it clear to her that we want HER best answer and that in all the families we are asking the mothers to give these answers. So to make it comparable from family to family, we need her to answer the questions without consulting with anyone.

2. The mother is concerned that she doesn't know the "right" answers! Make it clear to her that there are no right or wrong answers, and we want her opinion or best response to the

questions.

3. The mother asks you what is meant by "very satisfied" or tries to tell you how she feels and wants you to say whether that is a "very satisfied" or just a "satisfied": You MUST NOT help her arrive at an answer. If she is confused about the question itself, you can try reading the question to her as it is stated using intonation to try to make it clearer. Give her time to think about it. Allow the mother to be confused, if necessary. Give her a chance to figure it out. If that truly doesn't work you can explain the meaning of a word to her if that is the problem, but she must decide on the answer. So if she says something like, "What would constitute a very satisfied" or "I feel this way, do you think that is very satisfied" or "my baby does this, would you consider that fretful", reply that she must make that judgment; we are interested in what she thinks. Please see the Operations Manual for more specific rules regarding defining words for mothers.

If words are defined for a subject, please be sure that is recorded on the Questionnaire Log (the word that was defined and how it was defined). However, note that defining words is discouraged; defining words early in the protocol will encourage mothers to ask more and more questions. We want to encourage the mothers to use their best judgment. However, in cases in which you feel the mother's response would be invalid because she does not understand the meaning of a word, you may define that word for her. Some suggested definitions are given in the following

sections. Try to use those definitions.

4. The mother is filling out the questionnaire incorrectly, for example, by writing down the number of her response, instead of blackening the space: If you see that the mother is filling out the questionnaire incorrectly, stop her and tell her again what we need her to do. If the mother is marking too lightly, you may want to ask her to make her marks darker. These forms should be checked before going to the data center and responses darkened if necessary.

5. The mother expresses negative feelings about the questionnaires, a particular questionnaire, or a particular question (i.e., says the questionnaires are redundant, silly, trivial, or don't apply to her): You should be accepting of the mother's opinion, but DO NOT convey the impression that you think a questionnaire or a question is dumb, silly, or trivial. DO NOT be defensive and try to defend any specific measure or question. You may want to simply say something like, "Some questions may not be as relevant for you as for other people. Because this is a national study, we will be seeing many different types of families. For some families, this may be a relevant question. Please answer the questions as best you can". If the mother seems offended by any question, supportingly remind the mother that she can refuse to answer any question she wishes to.

6. The mother wants to change the order of the questionnaires or do some and not others: You should tell the mother that we need to do things the same way with each family

that we see, so we need her to do the forms in the original order and we want her to do all the forms. However, remind her that if there is anything that she doesn't want to answer, she doesn't have to answer it. If she insists on doing things in a different order, allow her to complete the forms her way. Indicate on the protocol that the order was changed and how.

7. The mother needs to leave and you haven't finished all the questionnaires or she's tired and wants to stop, but says she will fill out the other forms later and mail them in: You should encourage the mother to finish, but don't push too hard, we don't want poor data. You may leave the remaining forms and a self-addressed stamped envelope (which you should always bring) with the mother for her to mail back. Ask the mother to complete the forms by herself in the order they are given to her. Stress to the mother that you will need to receive the forms within a week. Call to remind her if you have not received them within four days. Pay the mother for the visit only after the receipt of all materials unless it is not her fault that the visit had to be curtailed.

C. Scripts and Problem Solving for Specific Questionnaires

The following sections deal with each questionnaire individually and information/concerns specific to that questionnaire.

1. Form 15D: MY FEELINGS

You should use the following script when introducing this

questionnaire: "In this set of questions, you are asked to rate how you have felt during the last week. Please read the instructions at the top of the form before you begin." Explain the misprinting if it confuses the mother. However, the designations above the columns are correct, so there should be minimal problems with this misprint.

Below are several suggested definitions if the mother has difficulty with these words:

"effort" ... work, try

"depressed" ... low in spirits

2. Form 15E: PARENTAL CARE

You should use the following script when introducing this questionnaire: "In this set of questions you are asked to rate how you feel about certain situations regarding parental care. Please read the instructions at the top of the form before you begin." If the mother says that a lot of these things have not happened yet, you should point out to her that the instructions say "as you are feeling now or think you will feel as your child grows older." So if something hasn't happened yet, they should respond according to how they think they will feel as their child grows older.

Below are several suggested definitions if the mother has difficulty with these words:

"adjust" ... get used to

"distressed" ... upset

"prefers" ... likes better or likes best

"unfamiliar" ... something you are not used to

or have not seen

"soothe" ... make to feel better

3. Form 15F: RELATIONSHIPS WITH OTHER PEOPLE

You should use the following script when introducing this questionnaire: "This group of statements deals with your relationships with other people. Please read the instructions at the top of the form before you begin."

Below is a suggested definition if the mother has difficulty with these words:

"encouraged me" ... gave me confidence or
support

4. Form 15G: COMBINING WORK AND FAMILY

This questionnaire is administered only to mothers who are employed 10 or more hours per week.

You should use the following script when introducing this questionnaire: "This group of statements expresses things people have said about what it is like to combine work and a family. Please read the instructions at the top of the form before you begin."

Below are several suggested definitions if the mother has difficulty with these words:

"rewarding aspects" ... good things

"prefer to" ... rather

"resentful" ... annoyed

"conflicting obligations" ... things you need to
do at the same time

"competent" ... able to do

5. Form 15H: FAMILY FINANCES

You should use the following script when introducing this questionnaire: "In this set of questions, you are asked about your financial situation. Please read the instructions at the top of the form before you begin." Note that item 6 is answered only if the answer to item 5 is "yes".

Many mothers fail to note items h through k. You are not supposed to call her attention to these items, as this will invade her privacy and possibly, invalidate the standardization of the questionnaire.

6. Form 15I: PARENTING EXPERIENCES

You should use the following script when introducing this questionnaire: "In this set of statements, you are asked about your experiences as a parent. Please read the instructions at the top of the form before you begin."

Below are several suggested definitions if the mother has difficulty with the meaning of these words:

"unending" ... never ending

"tied down" ...feeling like you can't get out

"strain" difficulty

"conflicts" ...arguments, fights

"companionship" ...company

7. Form 15J: JOB EXPERIENCES

This questionnaire is administered only to mothers who are

employed 10 or more hours per week.

You should use the following script when introducing this questionnaire: "These questions ask you about the concerns you experience in your job, as well the rewards. Please read the instructions at the top of the form before you begin."

Troublesome words have been defined in the section above (Form 7).

8. Form 15K: MY CHILD CARE

This questionnaire is administered only to mothers who are using nonmaternal child care more than 10 hours per week. If the father is the caregiver to be observed, do not complete this form.

You should use the following script when introducing the questionnaire: "These four statements ask you about the relationship between your caregiver and your child. Please read the instructions before you begin."

VI. AFTER THE VISIT (See Section 15.1 for more complete instructions)

A. Reviewing the Data Forms

After the visit is completed, look over the entire interview form to make sure that each item was completed and coded properly. In most cases, you should actually be able to check this information while the mother is completing questionnaires.

Before posting the data weekly to the DCC, have another interviewer review the forms to be sure they are accurately completed. There are many opportunities for oversights and a second "eagle eye" may spot them.

B. Documentation

After leaving the home, complete the Post Visit Ratings of Mother Child Behavior During Video & Entire Visit (Form 15 R), the Home Visit Report (Form 15 X) the Questionnaire log sheet and the Interviewer Report Form. In most cases, you will be able to complete the Questionnaire Log during the home visit.

VII. ENCOUNTERING UNUSUAL CIRCUMSTANCES

1. The mother asks to fill out the written questionnaires at another time and offers to mail them in, or, you/she has to leave before finishing the 15 month interviews and questionnaires: If you have not completed asking the information up to the mother's employment section, you should find another time to go back to the home. If you get to this point, however, you may leave the second set of questionnaires and a self-addressed stamped envelope for the mother to mail them back. Ask the mother to complete the forms by herself in the order they are given to her. Stress to the mother, however, that you will need to receive the forms within the week or we will not be able to include her in the study.

Call to remind her if you have not received them back within

four days. If there are also remaining interview questions, schedule a time to call the mother to complete these questions over the phone. This call should be made within the next working day, if possible.

2. The mother's partner is female: If the mother defines a woman as her partner, then all questions pertaining to partners in the interview should be asked with respect to this person. Substitute "she" for "he" wherever this is appropriate.

**Appendix A: Training and Quality Control for the Standardized
Interview and Questionnaires**

Training and Quality Control for the Standardized Interview and Questionnaires

Your actual training program will vary depending on whether the Research Assistants for the 15-month visit have already done the 1-month or 6-month visits and are familiar with the techniques for the structured interview and questionnaires. On March 1 through March 3, 1992, there will be a training program in Philadelphia to train Home visitors for all aspects of the 15 month visit. Information regarding how to prepare for that training will be distributed to sites in January, 1992. Until then, the following information may be helpful.

A. Training Experienced Research Assistants

For experienced visitors, we would recommend the following training procedures for the standardized interview and questionnaires. Give each visitor a copy of the Manual for the Standardized interview and questionnaires and of the interview and questionnaires themselves, and ask them to review everything before meeting. When you meet, discuss any questions they may have about the manual or the protocol. Then have the interviewers role play the interview with each other, taking roles that try out various family situations (mom at home, mom working at one-month and now, mom returned to work at 13 months, single parents). You can also use this meeting to review any questions on which you think your interviewers might need extra

practice.

Then, have the interviewers do just the structured interview and questionnaires with someone they don't know (perhaps a family you've used before for pilot-testing), but not one of the formal pilot families -- save them for the "full-dress-rehearsal" of the entire 15-month protocol. Have the interviewers tape-record these interviews, and then listen to them, using the Interviewer Monitoring Form to note any problems. Review these taped interviews with the visitors. If there are no serious problems, proceed to the full-dress-rehearsal.

B. Training New Research Assistants

New research assistants will need a complete orientation to the purpose of the structured interview and questionnaires. We would recommend that you follow the training guidelines for the one-month interview in training new visitors to do the structured interview and questionnaires, especially the role-playing and taped practice interviews. It takes several complete structured interviews before most research assistants are comfortable with the flow of this type of interview, and the guidelines for probing and confirming.

C. Quality Control

We will follow similar quality control procedures for the 15-month structured interview as were used for the 1-month. Two interviews will be completed and certified as reliable before

official data collection begins with each interviewer. After that, the interviewer will tape the first interview of each month.

These audiotaped interviews will be scored, using the Interviewer Monitoring Form, by the Site Coordinator, or other person designated to maintain the reliability of the structured interviews. The Monitoring Forms will be reviewed with the visitor and then sent to the DCC. If the visitor scores below 190, or has a score below 10 on any single category on the Form, the interviewer will need to conduct mock interviews until two consecutive interviews reach the 190/10 criterion again. The first two "live" interviews they do after this should also be audiotaped and scored using the Monitoring Form. Additional monitoring instructions can be found in Appendix E.

One Mother/Child interaction tape of each Home Visitor should be monitored each month by someone other than the Visitor using the Mother/Child Interaction Monitoring Form (15Y). Optimally, visitors may want to monitor each other's tapes so they may learn from both their own and other visitor's experiences.

The only criteria for "passing" reliability on the Mother/Child Interaction monitoring forms is that the Visitor must read the instructions to the mother exactly as they are written. If a Visitor fails to read the instructions properly, he/she should not administer the procedure again until there is evidence that he/she has memorized these instructions. The

monitors at each site must make the judgement as to whether a Home visitor needs extra training in other aspects of the administration and taping of this procedure.

Home Visitors will submit one tape per month for within site monitoring purposes. These tapes must include the Visitor giving the mother the introductory instructions. Since it is not always possible to get these instructions on tape, have your Visitor identify which tape includes these instructions. Promptly monitor all tapes and offer feedback to your visitors. The Monitoring Form (15Y) should then be sent to the DCC.

In addition, EVERY interview and questionnaire will be reviewed by someone other than the visitor conducting the interview to ensure that data is recorded correctly and that answers are coded accurately. We recommend that visitors review each other's interviews; we find this alerts them to the types of errors that are easily made in this kind of a protocol.

D. Cross-Site Reliability

We will follow the procedures used for the one-month protocol. The Site Coordinator, or other person responsible for scoring the visitors' interviews on the Interviewer Monitoring Form, will receive a packet of criterion Interviewer Monitoring Forms, tapes and interviews to use to establish their reliability.

Appendix B: Specific Forms to be returned to DCC

1. Interview sections 1 and 2
2. Questionnaires (included in booklet 3 to sites)
3. Interviewer report forms
 - a. Infant/Toddler HOME inventory
 - b. Post home visit interview with mother
 - c. Post home visit ratings of mother-child behavior
 - d. Videotaping record form
 - e. Home Visit Report
4. Physician Health Form
5. Interviewer Monitoring Form
6. Monitoring Form, the 15-Month Mother-Child Procedure

Appendix B: 2. Questionnaires

7. My Feelings (Form 15D)
8. Parental Care (Form 15E)
9. Relationships With Other People (Form 15F)
10. Combining Work and Family (Form 15G)
11. Family Finances (Form 15H)
12. Parenting Experiences (Form 15I)
13. Job Experiences (Form 15J)
14. My Child Care (Form 15K)
15. Physician Health Form (Form 15L)
16. MacArthur Communicative Inventory (Form 15M)

Appendix C: Forms NOT returned to the DCC

1. Interviewer Report Form (DM-D)
2. Questionnaire Log (150)
3. Physician Contact Form (15L-a)
4. Ear Infection Follow-up Form (15L-b)

Appendix D: Sample Letter to Physician

LETTER TO PHYSICIANS

date, heading

Dear Dr. X:

Your patient, Y is part of the National Institute of Child Health and Human Development Study of Early Child Care. The question we want to answer is, "How do children's early experiences in their family and in different kinds of child care contribute to their development?"

Parents can give us a great deal of information regarding their child's health, but some information (e.g. on fluid retention during and after otitis media) is best gathered from patient records of office or clinic visits.

Enclosed please find a signed consent form from your patient's parent and a health form. Your help is very important to us. Please have someone in your office take a few moments to fill out our form and return it in the enclosed envelope during the next couple of days.

If you have any questions about the information being requested or about the study in general, please feel free to contact _____ (Principal Investigator) or _____ (Study Coordinator) at _____ (telephone number).

Thank you in advance for your contribution.

Sincerely,

Name of Principal Investigator
Principal Investigator

Name of Study Coordinator
Study Coordinator

Appendix E: For Monitoring

Additional Monitoring Instructions

General Considerations:

The purpose of the Interviewer Monitoring Form is to document the reliability of the interviewers conducting the Standardized Interview and Questionnaires as part of the 15 Month Home Visit. At 15 months, these forms will be sent to the Data Coordinating Center after they are completed by a certified monitor at each site. They will be stored at the DCC as a permanent record of interviewer reliability.

Each form that is required to document the reliability of the interviewer must be sent to the DCC. This includes forms on the first two non-real subject interviews used to certify the interviewer, the first two "real" subjects, and the first interview of each month after the initial certification. In addition, if an interviewer does not pass reliability at any point, forms on the first two "non-real subjects" used to recertify the interviewer and the first two "real" subjects must also be sent to the DCC. A copy of all of these forms must also be kept at the sites.

The monitoring form itself is not devised to provide extensive feedback to the interviewers. For example, only violations of reliability should actually be recorded on these forms. Interviewers need to know both what they do incorrectly and those things that they do well. Therefore, while monitoring provides an excellent occasion to give feedback to the interviewers, we suggest that the monitor also make more extensive notes than those recorded on the actual monitoring forms to share with the interviewers. Also, while monitoring is required on a monthly basis, interviewers may desire feedback at shorter intervals. (Some sites tape all of their interviews so that each one can be gone over if the interviewer has particular questions about certain interviews.) In addition, it is strongly recommended that each interviewer be made as knowledgeable as possible about the actual monitoring procedures, even if they are not certifying to become a monitor of other interviewers. The more explicit and clear these monitoring criteria are to the interviewers, the more they will understand what it is we expect from them.

Some changes have been made to the monitoring procedures at 15 months. These changes are the product of feedback received from interviewers as well as from inter-site communication regarding these procedures. These changes are, in part, an effort to foster greater consistency across sites in the implementation of these monitoring procedures. Some of these changes seem minor but there are some important differences between the six and fifteen month monitoring procedures. Thus, monitors that were certified at six months must learn these changes and must recertify at fifteen months.

To facilitate the process of becoming certified monitors, we have developed detailed instructions regarding the use of the monitoring form. (These instructions supersede the instructions you received with the tapes). Because the Six Month Interview and the Fifteen Month Interview differ in some subtle yet important ways, we also point out where some of these differences may lead to errors on the administration of the 15 Month Interview.

If you have any questions regarding the general monitoring procedures or questions about how to use the monitoring form, please feel free to contact Wendy Robeson.

Instructions on the Use of and Scoring
of the Interviewer Monitoring Form
Lyz Jaeger and Wendy Wagner Robeson

Each category will be discussed as it appears on the monitoring form.

1. READS

This category has lead to the greatest between-site differences in the use of the monitoring form. The following things should be noted in this category:

a. The interviewer reads every question as it is worded, every time she asks the question (unless the interviewer is "confirming" -- see below). On re-reads, interviewers often don't repeat the whole question and they should be deducted points for this each time it happens.

b. The interviewer should read all response choices every time she has to read the options to the mother. Interviewers frequently make the mistake of only re-reading the options which seem closest to what the mother is saying. (This particular type of mistake also borders on becoming a directive probe, but will only be counted under "READS.") Points should be deducted every time that this occurs.

c. Also included under this category is how the interviewer states the information in parentheses. There are several different types of information in parentheses:

1. If CHILD/HUSBAND etc. is in parentheses, the interviewer should read the proper name of that person. Points are not deducted for saying 'your child' instead of the name but if the interviewer fails to say the name consistently, it should be noted to the interviewer.

2. If the information in the parentheses is a definition of the intent of the question, then it should be read to every respondent and should be read exactly as it is written when the question is first asked. For example, see Section I, Q# 23. Points will be deducted for not reading this information exactly as it is written.

3. In several cases, information that may or may not be relevant to a particular family is printed in parentheses. This information must be read if it is applicable to a particular family or else points will be deducted. For an example of this type of case, see Section I, Q# 26.

4. In many questions, the parentheses call for the Month of the last visit or call. A change that will be made in the manual will instruct interviewers to say, "...when we last visited/spoke with you" or "Since I last came to see you in _____" EVERY time the question states "Since MONTH". So the correct way of asking a question that begins with this phrase is: "Since May, when we last spoke with you,..." or "Since I last spoke to you in May". It is also acceptable to include the exact date of the last contact. The interviewer can refer to the exact date the first time the questions in a section include the word MONTH, as well as with the following one or two questions. However, after the first two or three questions, to include the exact date with every following question may jeopardize rapport and points should be deducted. If the mother asks when the last contact was made, then the interviewer can include the exact date when she re-reads the question. In addition, interviewers will be instructed to give the actual date of the last call or visit at the very beginning of the standardized interview and questionnaires.

d. Adding words to the question, especially in the middle of the question or at its end, counts as a violation of "READS" and points should be deducted for it even if it seems trivial. Sometimes, however, some questions can be prefaced in a way which does not count as a violation of "READS". For example, adding the word "And" to the beginning of the question or making a transition statement to a group of questions which has a clear ending before the question is asked (e.g. "This next set of questions also deal with your employment situation". "How many of your...") If the statement prefacing the question could conceivably alter the meaning of the following question, then it should be counted against reliability.

Interviewers are expected to make their own transitions between sections.

e. Omitting words should be counted as a violation of "READS" even if it seems very minor. For example, interviewer frequently left the word "up" off of Section I: Q:26. While this word does not change the meaning of the question, it does change the way it sounds and may affect how the mother hears the question.

f. The way the interviewer introduces each QUESTIONNAIRE section and each individual questionnaire will be monitored under "READS". While the interviewers do NOT have to read these scripts exactly how they are worded, they must convey the same information every time they say these scripts. The following information must be given:

1. Introduction to Section: Each time the interviewer introduces the transition to the questionnaire portions, they must tell the mother at least three things: 1) She may have seen some of these questionnaires before, 2) She should

answer these questions about how things are at the present time or how she feels right now and 3) she can ask the interviewer for help if she needs to.

2. Introduction to the Scripts: Each time the interviewer introduces a specific questionnaire, she must tell the mother two things: 1) The content of the questionnaire and the applicable time frame if there is one (see, for example, My Feelings), and 2) that she should read the instructions at the top of the form before she begins. These things must be said before each questionnaire or points will be deducted.

Frequent errors include such things as reading the actual instructions printed on the form to mothers, pointing out potential difficulties with particular questionnaires, and forgetting to ask the mothers to read the instructions before they begin. Interviewers should not be giving any more information than that stated above UNLESS the mother explicitly requests it.

g. Interviewers frequently fail to read the Work Update prompts exactly as they are written. Points should be deducted if they fail to do so.

h. The transition sentences in the interview do not have to read exactly as written. However, some sentences that used to be part of the transition scripts are now part of the question. See, for example, Section I: Q31 and Q35. These statements should now be read exactly as worded because they are now part of the question and if they are not read as worded, points should be deducted for reliability.

i. Frequently interviewers are treating the introductions to Section II: Q#26,27,28 as optional introductions. These must be read exactly as worded or else points should be deducted.

j. While it is useful to note every instance in which the interviewer has not read every question exactly as is written (except where they otherwise confirmed the information), the following do not count as errors under READS:

1. If an interviewer reads two words as a contraction rather than as two separate words, no points will be deducted. Be especially careful, however, that the interviewer does not inadvertently change the tense of the sentence. If this happens, points should be deducted for reliability.

2. If an interviewer prefaces questions with a word like "And" OR "Next". If the interviewer does this frequently, it is worth noting to the interviewer but will not count against reliability. Be careful, however, that the interviewer is not inserting words before the question that may alter its meaning. For example, adding "On Average" before a question changes the meaning of that question EVEN IF that is what is the implied intention of the question. If the respondent needs help remembering that something is "on average", the interviewer should read the question as is, and then "step outside of the interview" to clarify that the question is about "on average".

3. Changing prepositions such as "spoke to you" versus "spoke with you" does not count against reliability.

4. Changing articles such as "this" to "that" will not count against reliability.

5. Inserting the word "that" after the words "Would you say" will not count against reliability. See, for example, Section I: questions #31 and #35.

6. In Section II: Question #1, we would like interviewers to stop asking the part of the question "Have you started or stopped working at any jobs?". If they end up reading the whole question, do not count it against reliability.

7. In the Work Update prompts, the TAXES prompt may be read "Is this before taxes?" and no points will be deducted for reliability. This change was made because the question printed on the grid is not consistent with the question on the prompt sheet.

8. In Section II: Questions 23-28, points will not be deducted if interviewers do not read the phrase "Please choose one of ..." exactly as it is written.

9. And as already mentioned above, points will not be deducted if the interviewer says "your child" in the place of the child's name when the question states "CHILD".

There has been considerable controversy regarding how much and when interviewers should adhere to the "READS exactly" rule. Remember, interviewers can choose to CONFIRM (see below), "step outside the interview", TRAIN the respondent, and PROBE. All of these make the interview more "friendly" and accurate. If you have interviewers who are making consistent READS errors which you think are trivial, please discuss them with Wendy Robeson.

It is rare for interviewers to have flagrant violations of this rule. Usually the mistakes are small, such as omitting or adding one word to the sentence. Even though these mistakes can look small, they often have subtle, yet quite conceivable,

implications for the meaning of the question. While this rule may seem strict, it is important to note that many interviewers easily get to the point where they do not commit these errors and even if they commit four of these types of errors, they still pass reliability!

2. CONFIRMS

The only errors that are to be recorded here are those made when a question is confirmed rather than read exactly as it is written. Some people have put failure to confirm errors under this category but that is not the intention here. What we are really concerned with under "Confirms" is WHEN the interviewer does use confirmatory statement, do they use the meaning containing words in the original question.

A frequent error made by interviewers is that they attempt to confirm a mother's answer before they have enough information. Any case where an interviewer does not have full, clear information from the mother prior to asking the question, they should NOT confirm. If they do, this becomes a directive probe error and should be recorded as such.

A common mistake noted so far on the 15 month Interview is that interviewers are frequently confirming whether or not the mother moved since the 6 month visit. They are assuming that if the mother is at the same address, that she has not moved. This is incorrect. She easily could have moved and moved back in again since that time. This error is scored as a PROBE error since it is a directive probe.

Interviewers were told at the training that if they are confirming a question because of information they heard prior to the Standardized Interview and Questionnaire portions of the visit, they should repeat this information before they confirm the question so that the monitor will know that the interviewer actually had this information. For example, if you find out earlier in the visit that the husband is not longer employed, the interviewer could say something like, "When we were talking earlier in the visit, you mentioned that your husband is not now working for pay."

3. DEFINES

This category refers to definitions that the interviewer gives the mother during both the interview and the questionnaires. Errors to be included in this category include offering definitions of subjective phrases to the mother, giving incorrect definitions of words for which the interviewer is allowed to give a definition, not giving the manual definition of a word if it is defined in the manual, and failing to note definitions given on either the Questionnaire Log or the Interviewer Report Form.

4. RECORDS

There has been confusion over the use of this category and the "CODES" category. Errors noted under "RECORDS" generally refer to recording errors on questions where the interviewer must record exactly what the mother tells her in the form of pre-existing Scantron bubble choices. The interviewer has to make no coding decision on these types of questions.

Common problems with the 15 month Interviews were that interviewers forget to fill in the NA box for the secondary job in Section II: Question #2 and they also failed to fill in N's on Section I: Question #22 where applicable.

5. CODES

This category refers to questions where some coding decision is required by the interviewer. These questions are generally asked as open-ended questions and the interviewer determines which Scantron answer represents what the mother has said. The relevant items on the 15 Month Interview are: Section I: question #22 - 4c, 4d; question #23; Section II: Occupation code on Work Update, question #13, question #22). (Also, if Section I: #22 is asked simply as an open-ended question and answers are not confirmed with the mother, then errors in coding would also be noted here.)

The interview also calls for the recording of information that is not in the form of a Scantron answer. There are many places in the interview, for example, that ask the interviewer to "Specify". Although these answers may not seem as important as the Scantron answers, the answers to these questions should be recorded clearly and in a form that would be interpretable by someone other than the interviewer. If the interviewer consistently fails to record such information clearly over the course of the interview, count this as one instance of a disagree.

6. FAILS TO PROBE

A difficulty in noting these types of errors on the monitoring form is that they are likely to be confounded with recording or coding errors. Interviewers make coding and recording errors often because they do not have enough information, i.e. they failed to probe where it was appropriate. For purposes of the monitoring form, we will not double code interviewer errors. If a recording error is really the result of a failure to probe, record it only as a failure to probe. (If the recording error is the result of some other problem, record it under "RECORDS".)

Common probing errors include the following: 1) not getting sufficient information to record the mother's response exactly in the form that the Scantron options call for (for e.g. coding a Y

or N response when the mother has not actually said either yes or no), 2) not probing "Anything else?" on all open-ended questions (such as with section I, questions 36-40) -- failure to probe with one question will not result in deducted points but failing to do this twice will count as one failure to probe error and 3) not resolving factual contradictions during the course of the interview -- each error of this sort should be noted.

7. PROBES

Directive probes include any questions that may prejudice the mother's answer in any way. For specific examples, please consult section 15.4 of the Home Visit Manual.

There are other types of inappropriate probes that are not necessarily directive. For example, if an interviewer asks a mother the same question twice and the mother has previously provided an answer that fits into one of the acceptable response options, re-asking the question is an inappropriate probe. However, if the interviewer has clear evidence (i.e., an answer to an earlier question, the mother's statement that she doesn't understand the question or is unsure of her answer), repeating the question is often the best approach. Put simply, if interviewers have "evidence" of inaccuracy or confusion, it is okay to repeat a question. If they don't have evidence, they shouldn't repeat "just on a hunch".

All instances of directive and inappropriate probes should be noted in this category.

8. SKIPS

Several different types of errors should be noted under "Skips". Failure to follow skip patterns, and failure to ask or confirm any single question that should have been asked are all included under "skips".

An interviewer should generally not be penalized for getting too much information. The only exception to this is when the interviewer asks questions about a husband/partner when the mother does not have a live-in husband or partner. Asking such questions is likely to compromise rapport.

A question which many interviewers have had is whether a skip problem that is soon corrected by calling the mother and getting the missing information should be counted against reliability. The answer is yes, these errors, even if soon corrected by the interviewer count as a "SKIP" error. The interview is meant to be given in person, not over the phone. Also, calling the mother back is another imposition on her time which we should seek to avoid. IF, however, the interviewer catches their skip error before leaving the home and records these questions being asked of the mother, it should NOT be counted as a "SKIP" error.

One common problem noted with the 15 month interviews is that interviewers were failing to confirm the relationships of the household members to the mother and baby. If these are not confirmed, it should count as a skip error. Another common problem is that interviewers fail to confirm information especially when the mother answers the question in her answer to the previous question. Even if this happens, the interviewer is expected to confirm the information rather than to skip the question altogether. This is especially common with Section I: questions 20-22.

9. FEEDBACK

Interviewers must seek to avoid saying anything to the mother which may make her conscious about what the interviewer feels or thinks. Anything which conceivably could compromise the neutral context of the interview will count as a feedback error.

Several problems are common in this domain. First, interviewers still use words such as "O.K.", "Alright", etc. as filler between questions. While we are certain that many times mothers would not interpret this as an interviewer's evaluation of the mother's answer, we can never be sure that she won't interpret these words in that way. Thus, they are better avoided. (Also, when an interviewer uses these words repeatedly, she can sound as though she is cutting the mother off from offering additional information and trying to rush her through the interview).

A second problem that is common is that interviewers frequently want to say positive things to the mothers, particularly after they have expressed delight about something. For example, mothers are often happy to report that their babies had no health problems. Interviewers are likely to respond with statements such as "That's great". Unfortunately, what this seemingly nice comment may be doing is telling the mother that the interviewer would much rather hear about positive things rather than negative things such as health problems. Perhaps the best thing that an interviewer can do when a mother expresses delight or happiness is to "match" the mother's affect. For example, if the mother is smiling, the interviewer may smile too.

A third problem that interviewers have encountered is what to say if the mother expresses something that may seem very sad. In these circumstances, interviewers often want to offer words of sympathy. While this may seem like the polite and rapport-building thing to do, in some cases, the last thing the mother wants is for the interviewer to focus in on the issue by saying something about it. And, again, if the interviewer appears sad by what the mother has told her, the mother may censor other responses so as to not affect the interviewer's feelings. As with happy news, it is appropriate to match the mother's affect. If she appears sad, it's okay to say "I'm sorry to hear that" and then

continue the interview. It is important to emphasize that non-verbal behavior may be even more effective at expressing concern and respect for the mother's feelings than what the interviewer may actually say to the mother. Words are no substitute for sensitive, attentive listening particularly when the mother is discussing something distressing or of grave concern to her.

10. TRAINING

Training needs to occur both at the beginning and during the interview. One of the most common problems with training is that interviewers do not do enough of it, particularly with mothers who interrupt the interviewer. If a mother interrupts the interviewer more than twice while she is trying to read all of the response choices, the interviewer should train the mother by explaining the nature of the question. If this is not done, then sufficient training has not occurred and points should be deducted. In considering how to score this category, think of whether of the interviewer has made the mother's job as easy as possible.

11. PACE

This issue has not presented much of a problem for interviewers but a few things are worth keeping note of when scoring this category. First, make sure that interviewers are not speeding up as they read the response options. Second, make sure that even if the mother seems to be understanding everything, that the interviewer's pace is not too fast. Often, mothers want to rush through the interview because they have a time constraint and the interviewer speeds up to try to accommodate the mother. Instead of compromising the reliability and validity of the interview by reading the questions too quickly, the interviewer should tell mothers in this circumstance that they will try to complete as much of the interview as possible but that it might be necessary to either call her or visit her again.

CHAPTER 15

Section 5

ALTERNATE CAREGIVER PROCEDURES

(FOR USE IN SITUATIONS WHEN THE STUDY CHILD AND MOTHER ARE NOT
LIVING IN THE SAME HOUSEHOLD)

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CHAPTER 15

Section 5

ALTERNATE CAREGIVER PROCEDURES

I. OVERVIEW OF THIS MANUAL

This manual provides information about procedures to follow in situations when the study child and mother are no longer living in the same household. Included are decision rules for determining when alternate caregivers should be interviewed and when they should serve as participants in other phases of the project and general instructions for using the alternate interview forms.

Six sets of interview forms are described in this manual. The first, Form 16A, is used to determine who has legal custody of the child and who the child's primary caregiver is. Form 16B is to be used as an initial interview with an alternate caregiver. It includes a script for explaining the study and requesting participation and some background questions on the child's living situation. Form 16C is for use in all follow-up interviews with the same alternate caregiver. An alternate caregiver is defined as someone who lives in the same household with the child, provides a substantial amount of care, and is responsible for making decisions about the child. Anytime the child's primary caregiver changes, Forms 16A and B should be used. Forms 16D and 16E are similar in format and questions to the forms used for the 13, 22 and 34 month child care update and

scheduling calls. They should be used in conjunction with Form 10A, the Child-Care Grid, to determine if a child care visit needs to be done. Forms 16F and 16G are the alternate caregiver versions of the Standardized Interview given at each visit contact. These forms should be administered along with appropriate standardized questionnaires. Form 16H is the alternate caregiver version of the trimonthly phone call update.

All alternate caregiver forms are intended for use in either phone or in-person interviews at 15 months or any contact point thereafter. Thus, any project staff member who determines that a study child is no longer living with his/her mother should immediately use the procedures outlined in this manual to determine who the child's primary caregiver is and whether data collection from an alternate caregiver is appropriate. If so, the initial interview (Form 16B) should be administered to that person right away, or as soon as possible. (See Section 3, page 7, for information about obtaining consent from alternative caregivers.)

Copies of the alternate interview forms and the decision rules in this manual should be taken on home visits and kept in the lab and by every telephone used for interviewing. All project staff need to be familiar with the procedures to be used when alternate caregivers are identified. Delays in collecting identifying information are likely to result in the loss of the child to the study.

Because each situation in which a child is separated from his/her mother is likely to have unique aspects, the forms have

been written to try to cover a wide range of situations.

Interviewers must try to obtain as much information as they can about the child's household, health status, and primary caregiver, making additional notes as necessary to insure that the child's individual situation is thoroughly described. In addition, some flexibility in scheduling home, lab, and child-care visits may be required in these situations. The goal is to collect all observations for these children within the regular data collection windows if possible, but in some cases it may be necessary to extend beyond these windows to meet the scheduling guidelines given in this manual.

II. DECISION RULES ABOUT DATA COLLECTION WITH ALTERNATE CAREGIVERS

Issues of legal custody. At all sites, these forms and procedures should be used to collect data from alternate caregivers who have legal custody of the child. However, when caregivers DO NOT have legal custody of the child, collection of these data is determined on a site by site basis, depending upon both (1) interpretations of state laws pertaining to legal custody and (2) permission of the Human Subject Peer Review Panel at the sites.

Laws concerning caregiver rights and responsibilities differ from state to state. For example, some states require permission of the legal guardian for school enrollment and emergency surgery; school and hospital authorities will not accept permission from alternate caregivers who do not have legal

custody. Sites need to investigate state laws and common practices concerning caregivers who do not have legal custody before deciding whether to collect these data in cases where the caregiver does not have legal custody.

Approval of the Human Subjects Peer Review Board.

Independent of legal custody concerns are concerns as to whether Human Subjects Approval obtained at each site to collect data from the mothers and fathers in this study also apply to data collection from alternate caregivers. Practices at each institution differ, as do the Informed Consent Forms used in this study. Investigators at each site will need to decide whether Human Subjects approval is necessary for collecting data from alternate caregivers, whether they are legal guardians or not. For many sites, additional Human Subjects review may be necessary.

For these reasons, collection of data from alternate caregivers will vary across sites. Sites will be asked to report whether or not they are collecting data from alternate caregivers who are not the child's legal guardians. It is not intended that data from alternate caregivers will be analyzed with the data from mothers; it is likely that these data will be analyzed on a case-by-case basis. However, questions have been written in such a way that analysis of the data with all other common protocol data is possible.

There are a number of situations in which the alternate caregiver forms may be used. These are described below.

- A. Mother does not have legal custody (Sites may need to obtain additional Human Subjects approval to collect these data.)**

If the mother no longer has legal custody of the study child, the interviewer determines who the legal guardian of the child is. This person is then informed about the study and asked to continue the child's participation. Once consent is obtained, all home and lab visits and observations and all child-care information should be collected with the child's legal guardian substituting for the mother.

- B. Mother as legal custody but child has been removed from her household. (These cases may be included at some sites and not others, depending on state laws and their interpretations as well as on Human Subject Review decisions.)**

If the reason mother and child are not living in the same household involves the intervention of a social service agency or the legal system, the interviewers will identify the primary caregiver of the child, defined as the person who is living in the child's household and who is responsible for the majority of care and for making decisions about the child. This person is then informed about the study and asked to continue the child's participation. Once consent is obtained, all home and lab visits and observations and all child-care information should be collected with the child's primary caregiver substituting for the mother.

If the alternate caregiver is not included in the study, complete only Form 16A and 16C.

- C. Mother has legal custody but is not living with the child for another reason (These cases may require additional Human Subjects approval.)

If the mother is not living with the child because of work arrangements, travel, health, study or other reasons, and this situation is expected to continue for at least three months, the mother will be asked for permission to continue the child's participation in the study with the alternate caregiver. If the mother cannot be contacted, decisions to include the alternate caregiver need to be made on a site by site basis, depending on interpretations of state law and Human Subjects review decisions.

The alternate caregiver will be informed about the study and asked to continue the child's participation. Once consent is obtained, all home and lab visits and observations and all child care information should be collected with the child's primary caregiver substituting for the mother.

If the mother and child are separated for a period that is expected to be less than three months (i.e., because of an emergency or illness, for travel, or a special educational program), alternate caregivers should not be interviewed. Instead, an effort should be made (a) to contact the mother where she is, in the case of a phone call update, or (b) to contact the mother as soon as she returns to schedule home, lab and child care observations.

If the length of separation is unknown or indeterminate, and the mother cannot be contacted, a decision about collecting data from an alternate caregiver should be deferred until (a) three months have elapsed, or (b) the next major data collection point (15, 24, or 36 months) has arrived. That is, if the separation of mother and child is identified during a phone-call update, and no information about the mother's likely return is available, study personnel could call the family monthly for three months or until the next major data collection point. (It is most useful if one staff member assumes responsibility for tracking these situations.) If a few weeks prior to the 15, 24 or 36 month data collection point, no expected date of the mother's return can be given, identify the child's primary caregiver, inform him or her about the study, and request the child's continued participation. Once consent is obtained, all home and lab visits and observations and child-care information should be collected with the child's primary caregiver substituting or the mother.

III. OBTAINING CONSENT FROM ALTERNATE CAREGIVERS

Written informed consent is needed for the participation of alternate caregivers in home and lab sessions. Each site should prepare a version of their initial consent form for use in these situations.

If the initial interview with an alternate caregiver is being conducted over the phone, verbal consent may be acquired prior to the interview and written consent can be obtained on a

subsequent home visit or through the mail. If the initial interview is being conducted in person, obtain written consent prior to beginning the initial interview.

If the legal guardian or primary caregiver for the child is the father, you may already have obtained consent from him for some aspects of the study. It is still necessary to obtain his written informed consent to participate in all aspects of the study.

IV. IF THE ALTERNATE CAREGIVER REFUSES TO PARTICIPATE

Use the suggestions provided in earlier manuals to determine the reasons for refusal and to reassure the alternate caregiver. If your efforts are not effective and the alternate caregiver refuses participation, say,

"Thank you very much for thinking about it. We're very sorry not to be able to keep track of CHILD, but we understand your reasons. Would you mind if we sent you a card with our name and phone number on it in case you change your mind?"

Then be sure you have the correct address.

Do not drop the child from the study. It is likely that the mother may return to the household before the next data collection point. Future efforts to contact the family should focus on contacting the mother, as the alternate caregiver has refused participation and should not be asked again to become involved in the study. The address obtained from the alternate caregiver may be useful in providing a point of contact for the mother.

V. USING THE ALTERNATE CAREGIVER INTERVIEW FORMS

The alternate caregiver versions of the phone call and visit interviews were kept as similar as possible to the interview forms used in the regular study. Thus, for detailed information regarding the administration of Forms 16D, 16E, 16F, and 16H, the interviewer should refer to the manual chapters where these forms are described. Follow the procedures outlined in these chapters to the greatest extent possible. However, given the unique circumstances of alternate caregiving situations, some modifications in the questions, format and procedures for administering these interviews were required. This means that the person or people who will be responsible for conducting these interviews will need to be fully knowledgeable about both the regular procedures for completing these interviews with mothers as well as the procedures unique to administering these forms to alternate caregivers.

General Concerns in Administering the Alternate Caregiver Forms

1. Differences between phone call and visit interview protocols.

The Standardized Interview administered at the visit contacts and the phone call updates have different procedures for handling missing data from the previous contact. Both the child care update call and the trimonthly phone calls update information from the most recent contact even if a data collection point was missed. The Standardized Interview, however, updates information only from the month in which the

last call or visit should have occurred, even if this contact was missed. Please read the appropriate manual chapters carefully so that you can follow the same procedures when completing these interviews with alternate caregivers.

2. Conducting initial interviews with alternate caregivers.

Although the standardized interview and trimonthly call interviews ask similar information, they are not exactly the same. It is important to keep in mind whether you are conducting an initial interview in which EITHER Form 16H or Forms 16f and 16G are being conducted or the first contact in which each particular form is being administered. For example, if you have already completed a trimonthly phone call with an alternate caregiver, you will be able to update some questions on the Standardized Interview from the last trimonthly call. However, for some questions on Forms 16F and 16G, you will have to treat this interview as an initial contact because they were not covered on the trimonthly call update. We have tried to distinguish clear skip patterns on the interview forms for these different types of contacts.

3. Time Frames.

Several of the questions on the interview forms ask the interviewer to specify a particular time frame (i.e. Since MONTH...). As mentioned above, the Standardized Interviews and Trimonthly Call updates handle time frames somewhat differently if there was missing data from the previous contact. In addition, the interviewer who conducts interviews with alternate caregivers is also responsible for adjusting the time frames on

the basis of the alternate care situation. At initial contacts in which Forms 16F and 16G and Form 16H are administered, we may not be able to cover the time frame implied by the questions because the alternate caregiver has not been caring for the child long enough to report this information. In these situations, the questions can be rephrased using "Since you started caring for CHILD...". You will be asked in places on the interview form to specify which time frame you used in asking particular questions. As much as it is possible, it is critical that we keep the time frames comparable between the alternate caregiver interviews and the mother interviews.

A. Form 16A. Alternate Caregiver Identification

This form is for use when, at any attempt to contact a family, study personnel learn that a study child and his/her mother are not living in the same household. The primary purpose of this form is to identify the person who has assumed responsibility for the child and to obtain contact information for that person.

If the person you are talking to seems vague about the child's custody situation, expected length of the mother's absence, or other information about the child, try to get the name, address, and phone number of the child's primary caregiver (defined as the person living in the same household with the child who provides most of the care and is responsible for making decisions about the child in the mother's absence). The primary

caregiver should be the major source of information about the child.

If the child is not in the legal custody of someone other than the mother and the alternate caregiver is unsure but suspects that the situation will last less than 3 months, do not interview the caregiver. Send a Missing Report Form to the DCC for this assessment point. Do continue, however, to be in contact with the alternative caregiver on a monthly basis. If the child is still in the care of the alternative caregiver at the next assessment point, you can institute the appropriate interview and visit procedures with the alternate caregiver at that time.

The completed Form 16A should not be sent to the data center, but should be retained at the site for use in contacting the alternate caregiver. Eventually the form should be filed in the study child's confidential folder.

B. Form 16B. Initial Interview with Alternate Caregiver

Form 16B is intended for use when the child's legal guardian or alternate primary caregiver is contacted. Procedures for explaining the study and requesting consent are included.

Before you conduct this interview with the alternate caregiver, prepare some background information concerning the child's participation in the study thus far. This information can include when and where the child was last visited and at what ages your site has had contact with the child. You will explain this information over the phone as part of completing Form 16B.

Interviewers will need to use this form in conjunction with another type of data collection. For example, if the interviewer determines that the mother and child are not living in the same household during a phone call to collect child-care information and to schedule visits, then the initial interview for alternate caregivers needs to be administered along with Form 16A, 16D and 16E. Some flexibility on the part of the interviewer will be required in explaining the situation to the alternate caregiver.

Similarly, if Form 16B is completed when trying to do a trimonthly call update, Form 16H should be administered during the same phone call if possible. Finally, if Form 16B is completed at a scheduling call and it is determined that the mother has not been living in the household for 2 weeks or more, Forms 16F and 16G should be administered at either the lab or home visit whichever is appropriate to that assessment point. (If however, the AC seems reluctant to schedule a visit, complete the Standardized Interview over the phone and attempt to collect the other visit measures, including the questionnaires, at a visit.) If the mother has left the household less than 2 weeks previously, schedule the home or lab visits at least two weeks after the date the mother left. If the alternate caregiver seems reluctant about the visit, administer Forms 16F and 16G over the phone.

C. Form 16C. Follow-up Interview with Alternate Caregiver

Form 16C is intended for use during the every-three-month data collection points following use of the initial alternate

caregiver interview. Form 16C can be used for either in-home or telephone interviews. Because many family situations involving alternate caregivers may be unstable, sites will have most success following these children if one project staff member assumes responsibility for keeping in touch with these families on a monthly basis. Such monthly contacts are for purposes of keeping in touch, not data collection. The interview forms are to be used only every three months, following the standard data collection schedule for the study.

In getting an update on the child's household, the interviewer should first clarify the custody and general living situation of the child. Describe the situation as you know it and ask if there have been any changes. For example, you might say,

"When we talked to you in April, Jeremy was legally in his mother's custody but she had moved to Denver and he was living with you and his Grandad. Is that still the situation?"

If there has been a change in primary caregiver, use Forms 16A and B, the initial interview for alternate caregiver, not the follow-up interview. If the mother has returned and resumed responsibility for the child, use the standard interview forms for the study.

D. Form 16D 13, 22, 34-Month Alternate Caregiver Telephone Interview and Form 16E Child-care Information for Alternate Caregivers.

Form 16D is intended for use at the 13-, 22-, or 34-Month phone call to obtain information about child care and identify observable child-care settings. This form is used with the child care grid (Form 10A). Information from the call is recorded on Form 16E. Additionally, the call is used to schedule both home and lab visits. Home and lab visits should not be scheduled until at least 2 weeks have elapsed since the Alternate Caregiver began caring for the child.

Specific Information for Administering Form 16D:

One potential difficulty in administering this call to Alternate Caregivers is that the child may have stopped using a child care arrangement as a result of the change in primary caregivers. Some Alternate Caregivers may know little about the arrangement which stopped. Therefore, for Part 2, Stopped Care, these questions should be asked only in reference to care which stopped since the Alternate Caregiver started caring for the child. Do not record on the interview forms information about care which stopped prior to the Alternate Caregiver caring for the child. If the Alternate Caregiver seems to have reliable information about care which stopped prior to her taking over responsibility for the child, record this information else where for your files.

Please note, too, that whenever we ask the Alternate Caregiver for information about the child's age at onset of a

particular care arrangement, we distinguish whether that care began before or after the Alternate Caregiver started caring for the child. This is relevant to questions 6a-6c and questions 35b-36b.

E. Forms 16F and 16G - Alternate Caregiver Home Interview

Forms 16F and 16G, along with the appropriate questionnaires, are to be administered at visit contacts with the alternate caregiver.

To complete this interview with alternate caregivers, the interviewer must distinguish between two types of initial contacts with alternate caregivers. First, this may be an initial contact in which EITHER Forms 16F and 16G or Form 16H is administered. In other words, it is the first time that you are interviewing the alternate caregiver about household composition, family health, alternate caregiver employment and partner employment. Second, this might be the first contact in which Forms 16F and 16G are administered. In your first administration of these forms, you will follow skip patterns according to the type of initial contact this is. Thereafter, you will follow the skip patterns appropriate to repeat contacts. Being familiar with the differences between the questions asked on the trimonthly call updates and those asked on the Standardized Interview will make the appropriate skip patterns much easier to follow.

The time frames for completing the initial Standardized Interview with the alternate caregiver are a bit tricky. First,

as is the case with the regular forms, you will be asking questions in reference to two time frames: 1) Since the month in which the last trimonthly call should have been done and 2) since the month when the last visit in which the interview was conducted should have occurred. The difficulty in getting information on these two time frames is that the alternate caregiver may not have been caring for the child since the beginning of these time frames. In cases where the alternate caregiver has not been caring for the child during the entire time frame implied by the question, alter the question to read, "Since you started caring for CHILD..." If the alternate caregiver has been caring for the child longer than the appropriate time frame, read the question inserting the month of when we should have last collected this information, even though we did not get it.

F. Form 16H - 18, 21, 27, 30 and 33 Month Alternate Caregiver Telephone Contact

This form is to be used to collect information at the trimonthly telephone contacts with the alternate caregiver.

For this form, "initial contact" usually refers to the first time in which EITHER Form 16H or Forms 16F and 16G are administered. Most of the information covered on the phone call update is asked about on the Standardized Interview forms (16F and 16G). If the Standardized Interview has already been completed, follow the skip patterns appropriate to a "repeat contact" in Parts 1 through 4 of Form 16H. If this is an initial

contact in which either Forms 16F and 16G or Form 16H is completed, adjust all time frames by saying "Since you started caring for CHILD...". For all repeat contacts, update information from the last available contact.

Part 5 of Form 16H asks about child care information that is not covered as part of the Standardized Interview. At assessment points where we administer the Standardized Interview, these child care questions are asked as part of the 13, 22, 34 - Month calls (Form 16D). At the initial contact with an alternate caregiver in which Form 16H is completed, if Form 16D has not been previously administered, use the time frame "Since you started caring for CHILD..." when asking question 53, 62, and 64. If Form 16D has been administered previously, update these questions from that contact. If this is NOT the first time you are administering Form 16H, update these questions from the month in which Form 16H was last administered UNLESS Form 16D has been administered since that time. If Form 16D has been administered more recently than Form 16H, update these questions from the month in which Form 16D was administered.

VI. SCHEDULING DATA COLLECTION VISITS WITH ALTERNATE CAREGIVERS

Once it has been determined that data should be collected using alternate caregivers to substitute for the mother, all measures (home, lab, and child care) should be conducted following the designated schedule for each measurement point.

Home and lab observational measures should not be scheduled until at least two weeks have elapsed after the change in the

child's situation. Thus, if the change in caregiver is identified during the scheduling call to set up a home visit, the caller should: (a) identify the alternate caregiver and whether it is appropriate for the alternate caregiver to provide data; (b) if so, explain the procedures for the study, get verbal consent for participation, and arrange to get written consent; (c) conduct the initial interview for alternate caregivers; and (d) schedule a home visit for at least two weeks after the date when the alternate caregiver assumed responsibility for the child.

At times, the delay in scheduling may place the visit slightly outside the window for data collection for a particular measurement point. The visit should still be scheduled and the data collected, even if the timing is not right.

If, at later measurement points, the mother returns to the household and assumes responsibility for the child, two weeks should elapse before home or lab data collection visits are scheduled.

Child care visits can be scheduled according to the usual procedures. If a change in caregiver is associated with a change in child care, then the required two week adjustment period for the new care setting will be needed.

All measures should be administered using the alternate caregiver as a substitute for the mother. This includes the HOME, the Strange Situation, and the attachment observation at 24 months, all caregiver-child observations and play measures, and standardized assessments including the MacArthur Language

Inventory and the Bayley. In addition, the standard questionnaire measures should be administered to the alternate caregiver. If the interviewer strongly believes future participation of an alternate caregiver may be jeopardized by giving him or her all the questionnaires, a reduced set of questionnaires can be given. These must include:

My Feelings

Relationships with Other People

Family Finances

Parenting Experiences

The other questionnaires may be omitted. A note describing the caregiver's response and explaining the omissions must be included with the data sent to the Data Center.

VII. SUMMARY OF PROCEDURES TO FOLLOW WHEN STUDY CHILDREN ARE NOT LIVING IN THE SAME HOUSEHOLD WITH MOTHERS

1. Whenever legal custody of the study child changes, the legal guardian of the child should be the primary participant in the study with the child.
2. When the mother has legal custody, she is the first choice for data collection, and an alternate caregiver is used only if:
 - a) The child has been removed from the mother's care by the courts or a social service agency;
 - b) The mother is living outside the child's household for a period of at least three months or an indeterminate period that includes a major data collection point; or

- c) The mother has been out of the child's household, has returned, but is not assuming responsibility for the child.
3. When the child's primary caregiver changes (from mother to alternate, between one alternate caregiver and another, or from alternate back to mother) major data collection (home or lab visits) should not be conducted until the child has been with the new caregiver for at least two weeks. Child-care visits can be conducted on the regular schedule unless there have been changes in the child-care situation associated with the change in caregiving.
4. To the extent possible, all measures should be collected from alternate caregivers, including the 15-month HOME and caregiver-child interaction observation, the complete 15-month lab visit including the Strange Situation, the MacArthur Language Inventory, and the 24-month attachment observation in the home, as well as all 24- and 36-month lab measures.

Questionnaire measures should also be administered to alternate caregivers. If the visitor is convinced that administration of all the questionnaires is so aversive to the alternate caregiver that it jeopardizes his or her future participation, only the following questionnaires need to be administered:

My Feelings

Relationships with Other People

Family Finances

Parenting Experiences

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CHAPTER 16

FIFTEEN-MONTH, 24-MONTH, AND 36-MONTH HHS FATHER VISIT

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CHAPTER 16

FIFTEEN-MONTH, 24-MONTH, AND 36 MONTH HHS FATHER VISIT

I. GENERAL CONSIDERATIONS FOR THE FATHER VISIT

A. Your Role as a Visitor

As a home visitor, your main objective is to obtain accurate, reliable information in the most pleasant way possible. Home visitors must balance their professional role and objectives with their role of being a friendly, respectful guest in someone's home. Unlike the typical lab setting, many unexpected things arise in the home that require flexibility on the part of the visitor. Your flexibility conveys your respect for the person and the way they do things in their home. Your flexibility and openness, however, should in no way compromise your professional agenda. The tone of the home visit is that of a friendly, relaxed yet professional visit.

There are several ways that you can prepare yourself for this role. First, become totally familiar with the protocol. This familiarity will make you comfortable enough to be flexible and also will help keep your professional agenda in mind as you accommodate to the unique circumstances facing you. Second, become familiar with young children and the kinds of issues parents are concerned with at this time. Third, you can dress the part: wear casual, yet professional clothes (no suits or jeans). Fourth, continually examine for yourself any situations

that arise which prevent you from feeling totally comfortable with your role. Discuss these with your PI or site coordinator and see if there is a better way to deal with such situations in the future.

B. About Young Children

It is likely that the child will be present and awake at the time of the interview. It is important for the Visitor to be comfortable with young children and knowledgeable about their ways. Reading up a little extra on toddlers is a good idea for most Visitors. Site Directors can often recommend good reading materials.

Here we present a few crucial points, especially for those Visitors less familiar with young children. First, as soon as you see the child, notice and comment on something positive about this child to the father and mother. Not saying anything is sometimes taken as a slight; saying something honestly nice is easy to do about even the most difficult children. Be careful not to overdo it or to say anything judgmental that could be taken as negative -- even an innocent comment can stay in the father's mind for a long time. Second, if you feel that you may be contagious with any illness, be sure to reschedule or find a substitute. Even if you think that you are not contagious, fathers will not appreciate your coughing and sneezing around their children. Finally, Visitors may find it helpful to spend time around children who are this age.

C. When the Father Reveals Personal Problems

Occasionally, in a father's eagerness to talk, he makes an implied or direct appeal for help with his own personal problems. Sometimes, fathers can talk for so long about their problems that there may not be time to complete the questionnaires. The Visitor should be careful about feeling that he/she must handle these problems or solve them for the father. The Visitor might say something like *"I can understand your being upset (or concerned) about that. When we finish filling out the questionnaires, maybe we can talk about it more."*

Each site may want to develop its own resource list to meet the needs of its families on a case-by-case basis. The list may include the following information:

- Helpful books on parenting and development
- Fun things to do with your kid
- Child-care services
- Child-development services
- Health services
- Parenting-support services
- Crisis intervention
- Substance-abuse services

Although sites may have these lists of community resources for office use, we will not routinely give fathers any information concerning resources. This may constitute an intervention. For example, if the list contained information about "Fun Things to Do With Your Kids," we may subtly be

encouraging fathers to behave in certain ways with their children. If the father requests this information, however, we do have a responsibility to be reasonably trained to provide information about available resources.

Researchers at each site should be relatively familiar with the services that are available to parents in their area. If a situation arises in which a father requests information or some type of referral, the researcher may say something like, "I can see that you would like help. I am not (trained) (in a position) to help you, but perhaps you would like me to talk with Dr.----, our Director, and s/he will know of someone that could be of help to you." Immediately after the visit is completed, document the father's concerns and requests on the Visitor's Interview Report Form and discuss the situation with your Study Coordinator (SC) and/or Principle Investigator (PI). Get back to the father as promptly as possible with the appropriate information. If it seems appropriate to have your PI or SC speak with the father, the Visitor should ask if the father would like the Director to call.

Each site should keep a record of the kind of information distributed to a particular parent and what impact, if any, this had on the family's life, if known. (This can also be recorded on the Interviewer Report Form.)

D. When the Visitor Observes Family Difficulties

A more serious and difficult problem arises when something is revealed at the home visit that suggests that the child (or mother) is in "jeopardy." (See Principle 9 of the "SRCD Ethical Standards for Research with Children", Appendix H, Section 6.1.) For example, you may suspect some form of child abuse. Prior to conducting any home visits, the Visitor should become familiar with indicators of child abuse and the laws governing reporting this to the authorities in your state. You should immediately report to your PI what you saw or that you have suspicions of abuse despite hard evidence. A list of indicators and definitions of child abuse is included in Appendix A of the section 6.1.

E. Sharing Personal Information With the Father

Even though you are trying to establish a relationship with the father, you must avoid sharing personal information. By sharing such information, you may inadvertently establish certain response biases in the father as he assesses what your values may be. The reliability and validity of the data depend upon the visitor being able to establish an interpersonally neutral atmosphere. Making evaluative statements when the father tells you his opinion on a topic during conversation or sharing personal information with him are two major ways that a visitor can introduce bias into the data collected.

F. Confidentiality

We have guaranteed parents (in the Informed Consent Form) that all the information that we collect about them will be confidential and that all data will be kept confidentially, in a locked file cabinet. If you cannot keep confidentially (such as in a case of child abuse), you should stop the father and explain to him the limits of your confidentiality before you allow him to continue. Preserving confidentiality means, in addition, that you discuss data only with NICHD project staff and that you conduct visits only with families whom you do not know. In addition, avoid discussing families with other NICHD staff members who may be collecting more data on the family in the future, otherwise you may bias future home or childcare visitors' perceptions.

G. Expressing Appreciation

Be sure to emphasize at some point during the visit the importance of the father's contribution to the research, how worthwhile and important the research is, and how much the father's time is appreciated. This is often a good thing to do as you are leaving, if it hasn't come up before. Say something like, "We really appreciate your time. This research is important to understanding how children develop, so we appreciate that you are willing to help us with this."

H. Who can be a Father Home Visitor

The father visitor should be different from the research assistant who observes the father's child in child care. The father visitor may or may not have conducted the earlier father home visits.

I. Who can be a "Father"

The Father visited does not have to be the natural father of the child. However, he must be living in the home.

If the father was not in the study at 1 and 6 months, he can still join the study at 15 months or at 24 months if he wishes to. However, do not actively recruit fathers who refused to be in the study earlier. If a father changes his mind and wishes to be in the study, then he may join.

II. FATHER MATERIALS

A. Forms for the Father Visit

The following forms will be used in the following order during the 15, 24, and 36-month father visit.

1. Site cover sheet with address and checklist (Do not send to DCC) (For use at each site)

* 2. Form 12A Page 1 (cover sheet labeled "15, 24, 36-Month HHS Father Visit). This form gives the DCC the date, visitor ID number, subject number, and relationship code.

* 3. Form 12B (Attitude Toward Maternal Employment) This form will be given at the 15, 24, and 36-month HHS visits.

* 4. Form 12C & 12D (My Time Spent as a Parent, Parts 1 and 2) These forms will be given at the 15, 24, 36-month HHS visit.

* 5. Form 12E (Combining Work and Family) This form will be given at the 15, 24, and 36-month HHS visit.

* 6. Form 12F (Love and Relationships A) Two copies of this form will be in the 15, 24, and 36-month HHS booklet. This form will be given to both the mother and father at the 15 and 24-month visit. See below for more explanation.

* 7. Form 12G (Job Experience) This form will be given at the 15, 24 and 36-month HHS visits.

8. Other site specific questionnaires or procedures (Do not send to DCC)

9. Fathers Questionnaire Log (Form 12H) (Do not send to DCC) (This form will not be Scantron).

* 10. Visit Report Form (Form DM-F) (Send only the first page to DCC) (This form will not be Scantron)

NOTE: "Instrument Time Frame" on this form refers to what visit occurred, e.g., 15 month home, 24 month child care, etc.

11. One extra set of forms (to be read to the father in case he cannot read)

The starred forms should be copied. The original should be sent to the DCC and the copy filed in the site's files.

B. Form to be Completed by the Mother

Form 12F (Love and Relationships A) will be completed by both the father and the mother. At 15 and 24-months the mother may complete the form either during the mother visit or during the father visit. Sites may decide which procedure to use. If the form will be completed by the mother during the mother visit, then the form needs to be added to the checklist used by the mother visitor, and one copy removed from the 15, 24, 36-month HHS Father Visit booklet. At 36-months, mothers will complete Form 12F as part of the common protocol so it need not be administered to mothers as part of the HHS protocol.

C. Additional Materials Needed for the Visit

1. Self-addressed stamped envelopes in case the father needs to mail some forms.
2. An envelope in which to put completed data
3. Subject payment and receipt
4. The 15, 24, and 36-month Father Visit Manual
5. Several No. 2 pencils and pens
6. Writing board (Do not use a clip board, since the clip damages the forms.)
7. Map and directions to the house
8. Small change for the telephone

A checklist for common protocol materials has been included on the site checklist and address form. Each site may also want to develop a checklist which includes both common protocol and site-

specific materials so that the visitor can more easily prepare for each home visit.

III. CONDUCTING THE HOME VISIT

A. Window for Data Collection

The windows for each Father visit go as follows:

<u>Visit</u>	<u>Ideal Time</u>	<u>Regular Window</u>	<u>Exception Period</u>
15-Month Father Visit	The Week Before 15-Months	14 Months, 0 Days to less than 17 Months, 0 Days	17 Months, 0 Days to less than 19 Months, 0 Days
24-Month Father Visit	The Week Before 24-Months	23 Months, 0 Days to less than 25 Months, 0 Days	25 Months, 0 Days to less than 28 Months, 0 Days
36-Month Father Visit	The Week Before 36-Months	35 Months, 0 Days to less than 37 Months, 0 Days	37 Months, 0 Days to less than 42 Months, 0 Days

Ideally, the home visit will be scheduled and occur within one month before and after the child's 15, 24, or 36-month birthday (figured in months). If, however, the visit must be canceled for some reason or cannot be completed and must be rescheduled, you may reschedule using the information in the table above. If the data is collected in the exception period the principal investigator must then sign an Exception Period Data Form for this visit. See Chapter 14 for details on filling out this form.

B. Pre-Visit Preparation

Before going to the father's home the visitor should do the following things to prepare for the visit.

1. Directions and Map. First, the Visitor should check a map to make sure that the directions received from the father are

correct. Checking the map will also help the Visitor plan the time he/she needs to find the father's home and to anticipate delays.

2. Site Cover Sheets. Second, the Visitor should check that the appropriate information regarding the father's, mother's, and baby's names, address, phone number, and child's gender and date of birth are recorded on the Site Cover Sheet. Also record any special instructions about getting to the family's home (driving directions, parking, etc.). Information about travel time and mileage to the site are recorded during the visit so that future visitors will know how much travel time to plan. The name of the visitor is also recorded.

Before leaving for the home visit, check to be sure you have all the materials needed for the visit, using the checklist on the Site Cover Sheet. After the visit, once back at the project office, the Site Cover Sheet should be separated from the data and should be filed in the family's folder along with the Questionnaire Log Sheet and Interview Report Form, after discussing any problems or concerns with the Site Coordinator and/or Principle Investigator for your site.

C. Getting Acquainted and Establishing Initial Rapport

Upon arrival at the father's home, offer a friendly greeting, ask how everything is going, etc. For example, "Hello (Mr. Smith), I'm (Sue Darling) from the NICHD Study of Early Child Care at (Temple University). I appreciate your letting me

come out and visit with you today, especially since you must be pretty busy with (CHILD'S NAME). How has everything been going for you and your family?"

If the child is present show appropriate interest and say something nice about the child.

D. Filling Out the Questionnaires

After making small talk and establishing rapport with the father, say, "I have some questionnaires for you to fill out yourself. If you have problems with any of the questions, please let me know." Just be sure to let the father know that he should ask if he doesn't know what he is supposed to do. Also point out to the father that he will blacken in his answer as completely as possible in the appropriate space with the pencil which you will be handing him at this point.

Give the questionnaires to the father, one at a time, using some hard writing surface (not a clipboard, which creases the forms and jams the machine which read them.) The printed forms contain brief instructions for each questionnaire which you can encourage the father to carefully read. In addition, you should read aloud the instructions using the Questionnaire Instructions and Definitions Form (see Appendix of Chapter 16).

When the father finishes each questionnaire merely say "thank you," not "that's great" or even "fine." It is common for people to worry that they are doing questionnaires "right" (more about that later), so don't use any evaluative words that make

them feel that you are judging whether they did it "right" or not. Also, maintain some physical distance if possible so that the father doesn't feel that you are looking over his shoulder. You may want to inconspicuously monitor him just at the first to see that he is starting off correctly.

If it appears that the father cannot read, or if he is taking a very long time (very poor reading skills), you may offer to help him read. Do this only when you really feel that it is necessary. You can say something like *"We would like you to fill these out yourself, but if there's any difficulty, I will be glad to read the questions to you. I'll give you a moment to look at the forms and see what you think."* For this purpose, always take an extra set of the questionnaire forms. Read them to the father, help him keep track of where you are on the form if necessary, but if at all possible, let him mark his own copy of the form so that his answers are given as confidentially as possible.

If the father is having trouble doing the questionnaires because he is holding the child or the child is distracting him, you may offer to hold or play with the child while he does the questionnaires. If the father asks you to read the questions to him, and you know he can read, stress to him the importance of administering these questions in the same way to everyone and that we really need him to read the questionnaires. It is extremely important for several reasons that, if the father can read, he complete these forms himself. The visit moves faster,

the information is more standard, and the information is more private.

E. Checking Questionnaires

When the father hands back to you the first questionnaire, ask him if he would mind if you check it over to make sure that he did not miss an item that he did not intend to leave blank. Nearly every father will say that he does not have a problem with this. If he says that he does not mind, quickly look over the form to see if he has missed anything. You may wish to cover up the questions on the form as you look at the answers so that it is obvious that you are not reading his responses. Remember to check the back side of all forms. If he has left something blank, ask him if he intended to do so. If he did not intend to, ask him if he would like to add his answer at this time.

If the father says he doesn't want to answer that question, say "fine" and record on the questionnaire log that he refused to answer an item. If he says that he didn't know how to answer an item, ask him for his best answer. If the problem is that he doesn't understand a word, you can define a word for him. If the father does not want you to scan the questionnaires, ask him if he will quickly scan it for missing items for you. When this is complete (whether you scan it or the father scans it), place the questionnaire in an envelope so that it is clear to the father that his answers are now out of sight. If you find missing data

when you get back to the office that you didn't detect, call the father as soon as possible and get the missing response by phone.

We do not want to give the impression that we are reading the father's answers, because he may then censor responses on later questionnaires. If we read him responses or ask him about anything in particular he indicated on a form, he will see very little sense in having to complete the forms himself.

F. Father Questionnaire Log Sheet

As you check over each questionnaire, you will mark on a Father Questionnaire Log whether blank responses are refused information or if you were unable to check his responses on a particular questionnaire (in which case, it may just be missing data). This log will also have a place for you to indicate whether you had to read any of the information to the father and whether you suspect that some of the information may be unreliable (e.g., the father seemed harried and just whizzed through the questionnaire, he didn't seem to understand a questionnaire or certain items well, he can't attend well enough to respond, he expressed resistance, kept asking when this would be over, etc.). The form should be filed in the site's father visit folder for that subject and should not be sent to the DCC.

G. Responses To Common Problems

Several common problems have arisen in piloting. Following are some ideas for dealing with them.

1. The father asks someone else in the home to help with the questionnaire answers (e.g., his wife). Politely make it clear to him that we want HIS best answer and that in all the families we are asking the fathers to give these answers; to make it comparable from family to family, we need him to answer the questions without consulting with anyone.

2. The father is concerned that he doesn't know the "right" answers. Make it clear to him that there are no right or wrong answers, and we want his opinion or best response to the questions.

3. The father asks you what is meant by "very satisfied" or tries to tell you how he feels and wants you to say whether that is a "very satisfied" or just a "satisfied". You MUST NOT help him arrive at an answer. If he is confused about the question itself, you can try reading the question to him as it is stated using intonation to try to make it clearer. Give him time to think about it. Allow the father to be confused, if necessary. Give him a chance to figure it out. If that truly doesn't work you can explain the meaning of a word to him if that is the problem, but he must decide on the answer. So if he says something like, "What would constitute a very satisfied" or "I feel this way, do you think that is very satisfied," reply that he must make that judgment; we are interested in what he thinks.

If words are defined for a subject, please be sure that is recorded in the Questionnaire Log (the word that was defined and how it was defined). However, please note that defining words is

discouraged; defining words early in the protocol will encourage fathers to ask more and more questions. We want to encourage the fathers to use their best judgment. However, in cases in which you feel the father's response would be invalid because he does not understand the meaning of a word, you may define that word for him. Some suggested definitions are given on the Questionnaire Instructions and Definitions Form (see Appendix). Try to use those definitions.

If the father asks for clarification of a question or phrase which has not been defined in the Instructions and Definitions Form (see Appendix of Chapter 16), the visitor should not try to interpret the meaning of the question. Instead, the visitor should say something like the following:

"I see your problem with this question. Even though these questions are carefully tested, sometimes we have one that is not quite clear to some people or which doesn't quite fit everyone's situation. We need to get fathers' best answer to the question, as it is written. That way, we can compare your answers with other fathers'...Please read the question again and you give me the best, most accurate answer you can, given the way it was written." (Fowler and Mangione, 1990, paraphrased, p. 51-52.)

If the father asks for a definition of a particular word, the visitor may give one in certain cases even if it is not defined on the Instructions and Definitions Form. If the father simply does not know the meaning of a vocabulary word, you may offer him the definition. For example, if a father does not know

what "adaptable" is, you can tell him that it means being able to fit with the situation (the dictionary definition). When you do define a word for the father, keep your definitions short. In our experience, the more explaining you do, the more likely you are to get in over your head. If you choose to define a term for a father, record the definition you used on the Questionnaire Log.

4. The father is filling out the questionnaire incorrectly, for example, by writing down the number of his response, instead of blackening the space. If you see that the father is filling out the questionnaire incorrectly, stop him and tell him again what we need him to do. If the father is marking too lightly, you may want to ask him to make his marks darker. These forms should be checked before going to the data center and responses darkened if necessary.

5. The father expresses negative feelings about the questionnaires, a particular questionnaire, or a particular question (e.g., says the questionnaires are redundant, silly, trivial, or don't apply to him). You should be accepting of the father's opinion, but DO NOT convey the impression that you think a questionnaire or a question is dumb, silly, or trivial. DO NOT be defensive and try to defend any specific measure or question. You may want to simply say something like, *"Some questions may not be as relevant for you as for other people. Because this is a national study, we will be seeing many different types of families. For some families, this may be a relevant question."*

Please answer the questions as best you can." If the father seems offended by any question, supportively remind the father that he can refuse to answer any question he wishes to.

6. The father wants to change the order of the questionnaires or do some and not others. You should tell the father that we need to do things the same way with each family that we see, so we need him to do the forms in the original order and we want him to do all the forms. However, remind him that if there is anything that he doesn't want to answer, he doesn't have to answer it. If he insists on doing things in a different order, allow him to complete the forms his way. Indicate on the protocol that the order was changed and how.

7. The father needs to leave and you haven't finished all the questionnaires or he's tired and wants to stop, but says he will fill out the other forms later and mail them in. You should encourage the father to finish, but don't push too hard; we don't want poor data. You may leave the remaining forms and a self-addressed stamped envelope (which you should always bring) with the father for him to mail back. Ask the father to complete the forms by himself in the order they are given to him. Stress to the father that you will need to receive the forms within a week or we will not be able to include him in the study. Call to remind him if you have not received them within four days. Pay the father for the visit only after the receipt of all materials unless it is not his fault that the visit had to be curtailed.

8. The father or other household members ask for more detail about the study or about what questions we are trying to answer, try to rephrase the information in the consent form, timetable, or consult the information at the end of the Two-Week Telephone Interview. It is important that every family have a similar understanding of the project, so using these descriptions is best. If people press for more information than you have, or if they ask for information which may prejudice the father about the purpose of the study, tell the person that you are not sure what the answer is at this time, and that you'd like to check with the Director of the Project and get back to him. Never say "I don't think I'm supposed to tell you that," or "I'm not sure if I can tell you that." Families have the right to be fully informed. If you can't answer all of their questions, let them know that you will promptly get back to them with an answer and then follow through.

H. Debriefing

It is important at the end of the visit to "debrief" the father. Ask the father if there is anything that we didn't ask about that he thinks is relevant, or if he has any comments or questions about the questionnaires he'd like to share with us. This is necessary to give the father a sense that he is an important part of the research process and to give him the chance to express any adverse feelings he may have had about the visit. The visitor needs to be sensitive to any negative affect in the

father and needs to give the father a chance to share his feelings.

I. Paying the Father

Thank the father, and explain how important this study is, and how we value his time and help. Pay him, or make arrangements to pay him \$25 for the 15-month visit, \$30 for the 24-month visit and \$35 for the 36-month visit. If all of the information is not completed during the home visit and this is due to circumstances beyond the father's control, the father should be paid before you leave the home. If, on the other hand, the father cuts the visit short before completing all of the measures, then he should be paid when his complete information is received.

J. Preparing for the Next Contacts

Talk with the father about the next visit and phone call. "Someone from our team will call your wife/partner in three months. We will want to find out how your family and (CHILD) have been, whether anything has changed. Children change so much in the first few years, and things may be quite different in three months. The call should take less than 15 minutes."

"The next time I'll visit you in the home will be when (CHILD) is (24 or 36) months old. At that time, I'll bring questionnaires similar to the ones you filled out today. I'll

contact you a few weeks before (CHILD) is (24 or 36) months old to talk with you about the details of that visit.

K. Exiting

Leave the father with a good feeling about your visit. As you leave, give the father positive feedback along the lines of "You've really been helpful to us," "I've enjoyed meeting you, I'll look forward to visiting you again," "You really have a beautiful child."

IV. POST-VISIT CONCERNS

A. Reviewing the Interview Form

After the visit is completed, the Visitor should look over all the questionnaires to make sure that each item was completed. In most cases, the Visitor should actually be able to check this information while the father is completing the questionnaires. Before posting the data weekly to the Data Coordinating Center (DCC), have another visitor review your forms to be sure they are accurately completed. There are many opportunities for oversights and a second "eagle eye" may spot them.

B. Documentation

To document the visit, the Visitor will need to complete some forms after leaving the home.

1. Visitor's Interview Report Form. First, the Visitor will complete a Visitor's Interview Report Form. This form gives

the Visitor a place to record in more detail any extenuating circumstances that may have affected the Protocol, a place to describe the father's comments following the visit, and an opportunity to record any comments the visitor wants to make about the home visit. A copy of the first page (only) of the form is to be sent to the DCC along with the subject data. Another copy of the form is filed in the father visit folder for that subject at the site.

2. Contact Log Book. Finally, we also recommend that each site keep informal notes on each visit. Here you could include information about whom the Visitor met during the visit, general comments about the proceedings, and some non-protocol information about the visit such as things the Visitor may have discussed with the father, the name of the family dog, etc. This information may be useful in maintaining rapport during future contacts. Be careful not to include information that may bias future Visitors; only information that may help them respond as sensitive, friendly visitors to the family.

Appendix

Fifteen-Month, 24-month, and 36-month Father Visit

QUESTIONNAIRE INSTRUCTIONS AND DEFINITIONS FORM

FORM 12B: ATTITUDE TOWARD MATERNAL EMPLOYMENT

You should use the following script when introducing this questionnaire: *"In this set of statements, you are asked to rate how you feel about what happens when mothers of young children work outside the home. Please read the instructions at the top of the form before you begin."*

Below are several suggested definitions if the father has difficulty with the meaning of these words:

"secure" ... confident, safe, trusting
"independent" ... able to do for themselves
"psychological" ... mental
"productive" ... useful, good
"valuable" ... important

Form 12C & 12D: MY TIME SPENT AS A PARENT, PART 1 AND 2

You should use the following script when introducing this questionnaire: *"This set of statements is about how parents spend their time. Please tell us how much you and your partner are involved in the following activities. Please read the instructions at the top of the form before you begin."*

Below are several suggested definitions if the father has difficulty with the meaning of these words:

NOTE: TO OTHER SITES, PLEASE NOTE WORDS THAT SHOULD BE DEFINED HERE

Form 12E: COMBINING WORK AND FAMILY

You should use the following script when introducing this questionnaire: *"This group of statements expresses things people have said about what it is like to combine work and a family. Please read the instructions at the top of the form before you begin."*

Below are several suggested definitions if the father has difficulty with these words:

"rewarding aspects"...good things

"prefer to"...rather

"resentful"...annoyed

"conflicting obligations"...things you need to do at the same time

"competent"...able to do

FORM 12F: LOVE AND RELATIONSHIPS (A)

You should use the following script when introducing this questionnaire: *"This set of statements is about your relationship with your spouse or partner. Please read the instructions carefully at the beginning of the form."*

Below are several suggested definitions if the father has difficulty with the meaning of these words:

"neglected" ... overlooked

"unique" ... special

FORM 12G: JOB EXPERIENCES

This questionnaire is administered only to fathers who are employed 10 or more hours per week.

You should use the following script when introducing this questionnaire. *"These questions ask you about the concerns you experience in your job, as well as the rewards. Please read the instructions at the top of the questionnaire before you begin."*

Chapter 17

Section 1

OPERATIONS MANUAL FIFTEEN MONTH LABORATORY VISIT

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Chapter 17

Section 1

OPERATIONS MANUAL 15-MONTH LABORATORY VISIT

I. OVERVIEW OF THIS MANUAL

The laboratory visit at 15-months consists of a series of procedures designed to assess children's cognitive and socio-emotional development as reflected by the children's attachment security to their mothers, children's independent exploratory behavior and sustained attention, children's performance on a standardized cognitive test, and children's height and weight. Section 1 provides general information about the lab visit. Instructions on the Solitary Play procedure are given in Section 2. Instructions for the Strange Situation attachment procedure are given in Section 3. Instructions for administration of the snack and the administration of the Bayley are in Sections 4 and 5 respectively. The height and weight procedure is described in Section 6.

We have attempted to consider as many questions and contingencies as possible. However, situations that we have not anticipated may arise during the course of data collection. When you are presented with a situation that is not covered in the manual, capture it as accurately as possible (e.g., write down the details of the situation), then contact your PI or Kaye Fendt at the Data Coordinating Center. She will confer with the

relevant individuals and give you a coding decision, an interpretational decision, or whatever is needed. These responses will be distributed to all sites by e-mail. Each of these new decisions will then be recorded in an addendum to this manual that will also be distributed to all sites.

II. GENERAL CONSIDERATIONS FOR THE 15-MONTH LAB VISIT

A. Personnel to Conduct the Visit

Three people are necessary to conduct the lab visit. One person, the visit coordinator, is responsible for greeting the family, explaining each procedure to the mother, and generally coordinating the visit. The second person is the "stranger" during the Strange Situation. This person must be a woman and be familiar with the Strange Situation procedure. The person must be unfamiliar to the child (i.e. they should not have visited the child's home or child care at 15 months.) The third person is responsible for filming the Solitary Play, Strange Situation, and snack procedures. There are specific instructions for filming these procedures in the sections of this chapter for these procedures. If necessary, a fourth person should serve as a babysitter for siblings.

All the members of the laboratory staff should be friendly, relaxed, and professional when interacting with the visiting family. They should be thoroughly familiar with the laboratory protocol. This familiarity will help staff to be comfortable enough to be flexible when problems arise. Staff members should

become familiar with 15-month-old children. The staff should wear casual, yet professional clothes. Finally, if the visit coordinator or the "stranger" are contagious with any illness, they should find a trained substitute to conduct their portions of the visit.

B. Window for Data Collection

The windows for each visit at 15-Months go as follows:

<u>Visit</u>	<u>Ideal Time</u>	<u>Regular Window</u>	<u>Exception Period</u>
15 Month Lab Visit	The Week Before 15-Months	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
15 Month Home Visit	The Week Before the Lab	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
15 Month Child C. Visit	The Week Before 15-Months	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days

To be within the desired window, the lab visit may occur anytime from 1 month before (14 month, 0 days) to 1 month after the child's 15-month birthday (less than 16 months, 0 days). All visits (but, particularly the lab visit) should ideally occur as close to the child's 15-month birthday as possible. For a given family, the home visit should precede the lab visit. However, if the home visit is cancelled and is rescheduled for after the lab visit, do not cancel and reschedule the lab visit. The order of the lab and child care visits can vary. Lab visits should not be initially scheduled for the month after the child's birthday. This month should be used for make-up visits. If necessary, visits can be conducted up to 19 months 0 days. All visits conducted on or after 16 months 0 days will be "flagged" as an exception on the data forms and must be approved by a principal investigator. An EXCEPTION PERIOD DATA COLLECTION APPROVAL form should be sent to the DCC along with any data collected on or

after 16 months 0 days. See Chapter 14 for details on filling out this form.

Lab visits for more than one child may be scheduled on a single day, however a 2-1/2 hour block of time should be allotted for each visit. Piloting suggests that families are often late. Diapers need to be changed, etc. Allow sufficient length of time when scheduling families to avoid families having to wait for their visit to begin because another family is being observed.

Lab visits can be scheduled for the evening only if the family has a schedule which insures that the child is rested and fed at this time. It is better to go into the exception period than to schedule a visit for a time when the child is not rested and fed. Please see the 13 month phone call manual for further instructions on scheduling the lab visit.

C. Materials Needed for the Visit

Sites should have 2 sets of each toy.

- * Sent to sites from the Washington site
- ** Ordered by sites using order forms provided by the Washington site

Solitary Play

1. Stop watch (sites must supply this)
2. Doll with hair that can sit up (and should be left sitting)**
3. Miniature baby bottle*
4. Miniature hair brush*
5. Miniature spoon**
6. Miniature bowl**
7. Miniature tea pot with lid**
8. Sea shell*
9. Rectangular wooden block*
10. Wooden clothespin (No Springs)*

11. Two colored sticks (one yellow, one blue)*
12. Plastic "donut" (hole in the middle) which the sticks and the clothespin can fit through*
13. Fisher-Price toy telephone (with cord cut, so that receiver can be lifted to ear)**
14. Irregularly shaped piece of green washable tablecloth**
15. Little Tykes miniature car**
16. Four Little Tykes toy people (that can sit in the car as drivers)**
17. Toy horse*
18. Toy cat*

Strange Situation Procedure

1. Pull toy**
2. Plastic milk bottle and small objects*
3. Toy telephone**
4. Peg bench and plastic hammer**
5. Silver measuring spoons* and nesting measuring cups**
6. Stacking rings*
7. Shape sorter (Jumbo Knob Size Board)**
8. Bus plus driver*
9. Two adult sized chairs (site supplies)

Snack (Each site is responsible for these materials)

1. Adult-sized chair
2. Child size table and chair
3. A plastic container with a lid, containing:
 - a. Child cup with lid
 - b. Paper cup for mother
 - c. Cheerios in a small Tupperware container
 - d. One individually wrapped slice of American cheese
 - e. Four crackers in a small Tupperware container. (Sites may select different types of crackers. Because of changing dietary standards, sites may want to provide unsalted crackers).
 - f. napkins
4. Bottle of unsugared apple juice (enough for the child and the mother)
5. Baby wet wipes for clean-up

Bayley (Sites are responsible for ordering the Bayley)
(See Manual in section 17.5)

In addition, each site should have an area set aside for changing diapers. It should include a diaper changing table, disposable diapers, baby wipes, disinfectant for cleaning the diaper changing table, and dishwashing detergent for washing the toys.

D. Observation Rooms

Two different playrooms are needed for the 15-month lab visit. The first room (Playroom A) is to be used for the solitary play assessment. It is desirable that this room have a one-way mirror so that videotaping can be done from behind the glass. If this is not possible, then a camera on a stationary tripod can be used. In such a case, sites will generate a local solution to the problem of having the camera person in the room. To assure procedural consistency across sites, we recommend that the camera and camera person be behind a black curtain and a 5 foot high clear plexiglass shield be placed between the curtain and the play area. The shield is removable and can be put away when the room is used for other purposes. The camera will videotape through an opening in the curtain. The second play room (Playroom B) is to be used for the Strange Situation. It should look like a different room than playroom A. It MUST be equipped with a one-way mirror. The video camera for this procedure should be hidden behind the one-way mirror. The organization of these play rooms is specified in the sections of this manual detailing the Solitary Play and Strange Situation

procedures.

E. Health and Safety Concerns

Listed below are a few health and safety related issues that each site needs to consider as they make their final adjustments on their lab set-ups.

1. Be sure all electrical outlets are covered. In addition to covering the outlets in the experimental rooms, you may want to cover the outlets that are located in hallways which connect the solitary play room and the strange situation room, and any rooms where visiting siblings will be likely to venture.
2. All sites need to make sure that their toy washing facility is independent of the diaper changing area. The box of baby wipes provided for the mother during snack should not be the same box used for diaper changes. If at all possible, toys and dishes should be washed in a kitchen where hot soapy water is available for disinfecting the toys. Toys and dishes must be rinsed and then dried after washing.
3. Each site should develop a system/schedule for washing doll clothes on a regular basis.
4. The diaper changing area should include a diaper changing table, disposable diapers, baby wipes, and detergent for cleaning the diaper changing table. Do not use an absorbent pad on the changing table. After washing and rinsing the changing table, it should be wiped dry with a disposable towel.
5. Soiled diapers must be removed from the diaper changing area after each visit. Soiled diapers should be disposed of in a

plastic bag that can be removed from the diaper changing area by the visit coordinator after the visit has been completed. Hands should be washed after removing the diaper pail.

6. Each site should have access to a vacuum cleaner for cleaning up the floor around the snack area after each visit. This will be especially important when there are multiple lab visits scheduled on one day.

7. After consultation with faculty in pediatrics and nursing, four bits of advice:

- *Don't use Sidex (a very strong disinfectant)
- *Wash your hands
- *Rinse the toys and tables
- *Dry everything after washing with disposable towels.

III. ORGANIZATION OF THE VISIT

A. Confirm with the Mother the Evening Before the Visit

The Visit Coordinator should call the mother the evening before the visit to confirm the visit and make sure the mother is coming. At this time the Visit Coordinator should also gather the information necessary for determining whether the 15-month lab visit should be rescheduled.

During the call remind the mother that we can provide her babysitting money so that she can leave her other children at home. If the mother says that her husband/partner or a friend wishes to come, explain that they will need to observe from the observation room otherwise the child may be distracted by their presence. Finally, remind the mother that we will pay her \$25.00 and reimburse her for mileage.

A suggested script to follow is:

"Hi, I'm CALLER NAME from the NICHD Study of Early Child Care. I wanted to call to confirm your visit to our playroom that is scheduled for tomorrow at (TIME). We have found that the visit to our playroom works best when children are in good health and haven't had any big changes in their routine during the week before their appointment. Is CHILD currently ill? (COLDS ARE GENERALLY UNAVOIDABLE. WE ARE CONCERNED ABOUT FEVERS AND MORE SEVERE SYMPTOMS.) Has CHILD had any major changes in the amount or quality of time he/she has had with you? We'd prefer to see you on a day when you and your child have been together all day. If this is not possible, we'd just like to make sure that we avoid times, such as immediately following a pick-up from child care or after a lengthy shopping trip, when CHILD might be very tired."

For any of the following situations, the visit coordinator must reschedule the visit for at least two weeks later:

1. The child was separated from the mother overnight or longer during the past week.
2. The child has begun a new child care arrangement in the past week (in centers, a new caregiver does not constitute a new arrangement, a new room does).
3. The mother began or stopped working away from the home in the past week.

If the child has a fever or severe symptoms of some illness, then reschedule the visit for when the child has recovered. If the child has a slight cold, go ahead with the visit.

If the mother and child will not be together for the two hours immediately prior to the visit, then reschedule the visit for a time when mother and child will be together for the two hours before the visit.

If there have been no illnesses or unusual separations, then proceed:

"I look forward to seeing you tomorrow at TIME. Did you receive the instructions for getting to the playroom? Did you receive your parking permit? Will you be needing money to pay for a babysitter for your other children (IF APPROPRIATE)?" HANDLE ANY OTHER LOGISTICAL ARRANGEMENTS AS NECESSARY.

Finally, remind the mother to bring the MacArthur Inventory with her to the playroom.

B. Preparations on the Day of the Visit

The visit coordinator is responsible for the following preparations:

1. Making sure all toys are clean
2. Cleaning the diaper changing table
3. Arranging the toys in the Solitary Play and Strange Situation playrooms
4. Making sure a "stranger" and camera person are assigned to the visit
5. Arranging transportation for the mother and child, if necessary

6. Arranging parking for the family, if necessary
7. Preparing snack materials

The camera person is responsible for arriving sufficiently in advance of the visit to check and prepare both cameras and to film the initial family identification at the beginning of the tape. One hour preparation time is recommended in case there is a video malfunction to correct.

C. Family's Arrival

If necessary, the visit coordinator should meet the family in the parking lot, at the door of the building, at the elevator, etc. Care should be taken that the family does not become lost or have difficulty parking. (Free parking should be provided, if necessary). If the mother experiences an unpleasant or difficult trip to the lab, she will be less likely to bring the child to the lab at 24-months.

When the mother and child arrive, the visit coordinator should offer a friendly greeting, asking how everything is going, etc. For example, "Hello, Mrs. SURNAME, I'm VISIT COORDINATOR'S NAME. It's nice to see you again (if previously seen). I appreciate you bringing CHILD in to our playroom today. How has everything been going for you and CHILD?"

Be sure to notice and comment on something positive about the child to the mother. Not saying anything is sometimes taken as a slight. Saying something honestly nice is easy to do about most 15-month-olds. Be careful not to overdo it or to say

anything judgmental that could be taken as a negative -- even an innocent comment can stay on the mother's mind for a long time.

The initial greeting should take place in the hallway. After the greeting, the mother's and child's things (stroller, diaper bag, coats, bottles, etc., but not the mother's purse) should be stored in an office or room not being used for the Strange Situation or Solitary Play procedures. Tell the mother that if CHILD becomes hungry or thirsty, we will be providing a snack a little later.

Some children will come to the play session with some kind of security object (e.g., pacifier, blanket, doll). Ideally we would like the child to leave such objects with the mother and not have them down on the floor, but not at the cost of the child being so uncomfortable that he/she will not play. Thus, ask the mother to take the object in question away from the child, but let her know that if the child will seriously protest, we will not insist on it. Be ready to direct mother not to bother if it seems as if she may be too assertive in taking something away from the child and that this will upset the child. Once these materials have been stored, go to the Playroom A and begin the solitary play instructions, (see section 17.2). Ask the mother if she needs to change the child's diaper, go to the bathroom, or take care of anything else before the procedures begin.

D. Sequence of Procedures

Listed below is a brief summary of the sequence of the 15-month

lab visit.

1. Welcome and initial instructions for the mother
(Conducted in the hallway or office)
2. Solitary play (10 Minutes) (Conducted in
Playroom A)
3. The Strange Situation (25 Minutes) (Conducted in
Playroom B)
4. The Snack (10 Minutes) (Conducted in Playroom B)
5. The Bayley (MDI) (15 Minutes) (Conducted in
Playroom B)
6. Growth Measures (5 Minutes)
7. MacArthur Inventory (If mother did not complete
before the visit) (20 minutes)
8. Wrap-up (Debriefing, Thank you, Payment,
Discussion of the Next Visit) (10 Minutes)

**E. Instructions for Completing the Laboratory Visit
Monitoring Form (Form 14I)**

At the end of the lab visit the visit coordinator should ask the mother questions 1-7 on the form.

The questions do not need to be asked using the exact wording on the form.

All mothers should be asked questions 1, 2, 6, and 7. If the mother reports that it has been a typical day in response to question 2, then do not ask questions 3 and 4.

For question 5, "Number of hours since child was picked up

at child care?", fill in the number of hours since the child was picked up from care on the day of the lab visit. If the child was picked up from care the previous day or earlier in the week then fill in NA (Not Applicable). Do not ask this question if the child is not in child care.

For question 7, if the mother answers yes then ask the second half of this question. Then code her response using one or more of the choices. Do not read her the choices.

For question 8 and 9, the visit coordinator should complete these questions based on his /her observations during the visit and on comments the mother may have made during the visit.

Items 10, 11, 12, 13, and 14 should be completed by the visit coordinator after the family has left. These items will provide the site and the DCC with a record of which procedures were successfully completed and the reason for failure to successfully complete a procedure. For each item, indicate whether the procedure was successfully completed. If the procedure was not successfully completed then indicate why the procedure was terminated or unsuccessful. The visit coordinator should choose the reasons for the failure to complete the procedure successfully. The Lab Visit Monitoring Form should be sent to the DCC in the next Monday mailing.

The visit coordinator should then reschedule the procedure within the window (including the exception period). A lab Monitoring Form should be completed for subsequent lab visits and sent to the DCC.

The following are the criteria for the successful completion of the measure:

Solitary Play - The Solitary Play procedure is successfully completed if ten minutes of video tape are obtained from the time the child is placed on the floor. If the procedure is not successfully completed, then the procedure must be repeated in the lab as soon as possible.

Strange Situation - Sue Spieker will judge whether the Strange Situation is successfully completed. If all the episodes were not completed during a visit, then send the tape to Sue Spieker immediately. Include a note explaining the problem and that the tape needs to be coded as soon as possible. Seattle will then notify the site as to whether the Strange Situation was successfully completed or whether the procedure must be repeated after 4 weeks have elapsed.

Bayley - The Bayley is not successfully completed if the tester had to omit 3 or more items (this does not include refusals). In addition, if the tester does not successfully establish a ceiling, (10 failures in a row), then the Bayley is not successfully completed and the entire Bayley must be repeated. (A previously established basal level can be used on the second test).

Height and Weight - The Height and Weight procedure is successfully completed if measurements of both height and weight are obtained. If the procedure is not successfully completed then repeat the procedure if there is a lab revisit scheduled to

complete one of the other procedures. Do not schedule a second lab visit to collect only the Height and Weight procedure.

MacArthur Inventory - If the mother has filled out the Inventory then collect it and mark on the monitoring form that it has been collected. If the mother has not completed the form, then have her complete it at the end of the lab visit. If the mother has completed the form but forgot to bring it to the lab, then give her a postage paid, addressed 9 x 12 envelope and ask her to mail the form to the site. Mark on the monitoring form "yes" for "re-distributed".

F. Expressing Appreciation

Be sure to emphasize at some point during the visit the importance of the family's contribution to the research, how worthwhile and important the research is, and how much the family's time is appreciated. This is often a good thing to do when the mother and child arrive and when they leave.

G. Handling the Presence of the Father or Other Children

Because some mothers may come to the laboratory with their husband/partner and/or other children, sites should develop procedures to accommodate other family members during the lab visits. Sites should have a room available in which family members may wait. The room should be equipped with toys and something for the father to read. Sites should provide a person to supervise the siblings of the study child if the father is not

present. Family members, if they are quiet, may observe the visit from the observation room. Under no circumstances can family members be present in the playrooms during Solitary Play, Strange Situation, snack, or the administration of the Bayley.

H. Taping the Visit

The Solitary Play, Strange Situation and snack procedures should be recorded on the same videotape. (Although there are currently no plans to code the snack as part of the common protocol, many sites are interested in this procedure and comparable taping procedures should be conducted). The specific instructions for taping each procedure are included in the sections describing the particular procedures. The following general instructions apply to all filming done during the laboratory visit.

1. Before the family arrives, record (both visually and audibly) the following subject information on the tape.

NICHD Study of Early Child Care
15 Month Solitary Play
Subject #
VC #

2. After filming the board in the solitary play room, change the words "Solitary Play" to "Strange Situation" and place the board in the strange situation room propped up against the toys so that it can be filmed again just before the mother walks into the room for the Strange Situation. The Visit Coordinator should then retrieve the board when she/he escorts the mother

into the Strange Situation room.

3. After the family has left, record on the tape using the same procedure as at the beginning of the tape, "end subject 920001".

4. Family and staff who are observing any part of the procedures from behind the one way glass must not talk during the visit. It is important not to distract subjects in the playroom and talking can be heard through the observation window. If it is necessary to communicate, soft whispers must suffice.

5. Staff who are filming procedures from behind one way glass and all persons standing near the one-way mirror should wear dark-colored clothing. Otherwise, the reflection of light-colored clothing will be captured by the videocamera and reduce picture quality. Lights in the observation room should be turned off or turned very low during filming because video cameras catch the reflection of the light against the window.

I. Ending the Visit

1. Completing the MacArthur Inventory (if necessary)

The mother will have been asked by the home visitors to bring the completed Inventory with her to the laboratory visit. After the Bayley has been completed, ask the mother for the Inventory. If she has forgotten to bring it but has completed it, make arrangements for her to mail it to the Visit Coordinator. Give her a postage paid 9x12 envelope for this purpose. If the mother has not yet completed the Inventory, have

her do so at this time. Keep the child occupied during this time so that the mother can concentrate on the form.

2. Debriefing

At the end of the visit, the mother should be "debriefed". Ask her if she has any comments or questions about the visit she would like to share with us.

3. Paying the mother

Thank the mother for all her time and help. Reiterate how important the study is, and how we value her time and help. Pay her \$25.00, or make arrangements to pay her.

4. Reimburse the mother for mileage driven to the laboratory

Reimburse or make arrangements to reimburse the mother for the mileage to and from her home and the laboratory. Use the rate and procedures determined at your site. If possible, prior to the lab visit, determine the mileage to and from the mother's home and the laboratory by using the mileage obtained from the home visit form. If possible, reimburse the mother for transportation costs at the end of the laboratory visit.

5. Preparing for the next contact

Talk with the mother about the next contact. If the Solitary Play, Strange Situation, or Bayley were not successfully completed, then a second lab visit should be scheduled. Usually, the home visit will have already been completed. If not, make any necessary final arrangements. For children who are in child care, the child care visit may or may not have already taken

place. If it has not, remind the mother of this visit and answer any questions the mother may have. For many families, the next contact will take place at 18-months with the Phone Call update. Prepare the mother for this call. Say something like, "We will call when CHILD is about 18-months to talk with you about any changes that have happened in your life".

6. Departure

Leave the mother with a good feeling about the visit. As she leaves, give the mother positive feedback along the lines of "You've really been helpful to us." "I've enjoyed meeting you, I'll look forward to seeing you again." "It was a pleasure seeing CHILD."

J. Lab Visit Log Form

This form should be posted and used by the lab staff. It will be used to keep track of the different tasks and responsibilities. Do not send it to the DCC. Each site may modify as needed. (See Appendix, Section 17.1).

IV. POST-VISIT ACTIVITIES

A. Checking the Data

After the visit is completed, the camera person should check to make sure that the videotape of the Solitary Play and Strange Situation procedures is codable. The Visit Coordinator should check over the Bayley to make sure all the information is correct and complete.

B. Documentation of the Visit

The Visit Coordinator should enter any pertinent information on the family and the visit in the site's Contact Log Book.

C. Copying, Labeling, and Sending the Tape

Copying the Videotape

Each procedure will be videotaped simultaneously on two tapes. Each will include the solitary play, Strange Situation, and the snack procedures. Of the two original tapes, one should be sent to the Washington site. After coding, the Washington site will send their tape to the Data Coordinating Center at NICHD. The second original tape should be retained at the site. In addition, the solitary play portion of the tape may be copied onto the tape that will be given to the family at the end of the study. (Other possible segments to include on the family's tape are the mother-child interaction at 6- and 15-months).

Labeling the Tape

The two original videotapes should be labeled using the labels provided by the DCC. The date of the visit should be written in the space provided on the label. The labels should be placed on the outside spine of the tape and the tape box. Be sure the label on the tape is not covering the hole created by punching out the tab. This hole prevents the tape from being recorded over and the tab should always be removed after the tape has been made. Do not include any other identifying information on the box or the tape.

Where to Send the Tape

One original of the tape should be sent by regular mail for coding to the following address:

Dr. Susan Spieker
CDMRC, WJ-10
University of Washington
Seattle, WA 98195

Where to send the Bayley Score Sheets and the 15-Month Lab Monitoring Form

The Bayley Score Sheet should be sent to the Data Center. Be sure to include an appropriately completed Multi-Purpose Cover Sheet (Form DM-I) with the Bayley Score Sheet. See Chapter 3, "Data Management and Paper Forms Handling" for information on posting this form to the DCC. A copy of the score sheet should be kept at the site.

D. Cleaning Up After the Visit

The Visit Coordinator is responsible for insuring that the toys are cleaned after the visit. The toys should be washed using hot water and dishwashing soap. The scale and infantometer should also be washed. The diaper changing table should be cleaned with disinfectant, if it was used.

V. ENCOUNTERING UNUSUAL CIRCUMSTANCES

Any number of circumstances can arise which could potentially derail the successful implementation and completion of the laboratory visit. Listed below are several possible

problems that might be encountered and recommended solutions. It is impossible to anticipate all potential problems. The visit coordinator should thus maintain an attitude that permits "thinking on his/her feet" in order to successfully confront challenges that might arise. Foremost to keep in mind are (a) the needs of the mother, child, and family and (b) our desire to obtain high quality data. Solutions that seriously discomfort families and breed resentment which could undermine further participation in the project must be avoided. At the same time, however, the visit coordinator must be prepared to work hard to find a solution that will enable him/her to obtain high quality data consistent with the other sites.

A. Video Malfunction

Videocameras should be tested an hour before the visit. If the equipment is not working and cannot be fixed and another camera is not available, then the family should be called and the visit rescheduled. If the family cannot be contacted before they arrive at the playroom, then either Bayley can be conducted and the rest of the visit rescheduled OR the whole visit can be rescheduled. Each site should develop a schematic diagram of the equipment setup and a troubleshooting guide to aid camera persons when troubleshooting.

1. Solitary Play Procedure

If there is a camera malfunction during the solitary play

procedure, the following rules should be followed.

a. Ten minutes of tape from the time the child is placed on the floor are needed for successful completion of the measure.

b. If during the procedure the camera operator suspects there is a problem, he or she will stop the videotaping and try to fix the problem on the spot. He/she will then resume videotaping to the end of 10 minutes from the time the procedure started. He/She will then report that videotaping of play was stopped, indicating when the stopping occurred. To the extent possible, information about the exact time at which failure occurred and taping resumed will be noted. If the exact time of interruption in taping is not known, an estimate will be provided (e.g. beginning, middle, or end of session).

Once the procedure is completed, the tape should be taken to the second videotaping area in which the Strange Situation session is being recorded. After the Strange Situation and snack are recorded, the camera person should rewind the tape and insure that codable quality material was recorded. If the procedure was not correctly taped, then the Solitary Play procedure should be attempted again after the Bayley is completed if the child is not too tired. If the child is too tired after the Bayley, then the Solitary Play procedure must be done during a revisit.

2. Strange Situation Procedure

If there is a camera malfunction during the Strange

Situation Procedure, then the following rules should be followed:

a. It is almost always necessary to have both mother-child reunions on tape for the tape to be codable. If this minimum has not been met because of equipment problems, then the Strange Situation procedure may need to be redone after 4 weeks have passed. Send the tape to Susan Spieker who will make the decision whether or not the tape can be used or if a revisit is necessary. If the child is older than 19 months 0 days in four weeks, then the Strange Situation procedure should not be done again and the data will be considered missing.

B. Family has Difficulty Coming to the Laboratory

Sites should make every effort to make sure the family is able to come to the laboratory. Transportation can be provided. Staff should be flexible about working whenever the families can come (evenings, weekends, schooldays, whatever).

1. Mother has child care difficulties

If there are siblings who need to be cared for during the visit, the site should offer to pay for babysitting or provide someone at the laboratory to babysit the siblings during the visit.

2. Mother does not have a car

If the mother does not have a car, the site should offer to pay for a taxi to bring the mother and child to the playroom. The site should arrange for free parking and reimbursement for mileage for mothers who have cars.

C. Child Arrives Tired or Ill

If the child is tired or ill, the visit coordinator will need to judge whether the visit should be cancelled and rescheduled. The visit should be rescheduled if the visit coordinator believes that the child's behavior will be seriously affected by the child's condition.

D. The Family Does Not Arrive

If the family does not arrive at the scheduled time, the visit coordinator should call the home to determine if the mother forgot or is having difficulty with transportation. If the mother forgot the visit, the visitor should first attempt to have the mother come immediately. Otherwise, the visit should be rescheduled. If the mother is having difficulty with transportation, the visit coordinator should arrange for a taxi and pay for the taxi upon its arrival.

E. Number of Times a Visit Can Be Rescheduled

The visit may be rescheduled as many times as necessary. However, the visit must take place before the child is 16 months 0 days of age. If a visit is completed when the child is between 16 months 1 day and less than 19 months 0 days old, then this data must be flagged as late. Visits should not take place on or after the child is 19 months 0 days old.

F. Child Needs a Diaper Change

If the child has a bowel movement and needs a diaper change

in the middle of the procedure, the child's diaper should be changed immediately. Show the mother where she can change the diaper. (Sites should have a diaper changing area available). When mother and child have returned to the play room, pick up where you left off. The only exceptions to this rule would be if there were only a minute or two to go for a certain procedure, or if the child were in the middle of a Strange Situation reunion. The Strange Situation is a special challenge and the visit coordinator must use common sense to decide when to interrupt the procedure. It is always okay to change a diaper during Episodes 1, 2, and 3. If the need arises during Episode 4, send mother in after a couple of minutes (thereby moving into Episode 5), have the reunion, and then pause for the diaper change. If the need arises during Episode 5, wait a couple of minutes, then pause for a diaper change. It is okay to shorten Episodes 6 and 7 if the need arises then. Complete Episode 8 and then have the diaper change. Do not ever interrupt the Strange Situation between Episodes 6 and 8, if possible. If you must, shorten 6 and/or 7 a bit and finish 8 before changing a diaper.

G. Procedures of Revisits

For any lab procedure that was not successfully completed (except the growth measures), the family should come back to the lab for one additional visit. If more than one procedure needs to be conducted during the return visit, then the procedures should be conducted in the standard order for a regular lab visit. The following are the criteria defining a successful

completion of a procedure and the rules for when to schedule a return visit:

Solitary Play - The Solitary Play procedure is successfully completed if ten minutes of video tape are obtained from the time the child is placed on the floor. If the procedure is not successfully completed, then the procedure must be repeated in the lab as soon as possible within the lab window (including the exception period).

Strange Situation - Sue Spieker will judge whether the Strange Situation is successfully completed. If all the episodes are not completed during a visit, then send the tape to Sue Spieker immediately. Include a note explaining the problem and that the tape needs to be coded as soon as possible. Seattle will then notify the site as to whether the Strange Situation was successfully completed or whether the procedure must be repeated after 4 weeks have elapsed.

Bayley - The entire Bayley must be repeated during a second lab visit if the tester omits 3 or more items (this does not include refusals), or if the tester does not successfully establish a ceiling, (10 failures in a row). The visit coordinator may not present only the omitted items for the second administration - a complete Bayley should be administered. (However, a basal level established during the first 15-month lab visit can be used on the second test).

Height and Weight - to be successfully completed, measurements of both height and weight must be obtained. If the

procedure is not successfully completed, then redo both the height and weight procedures if there is a lab visit scheduled for other procedures. Do not schedule a lab revisit in order to administer only the height and weight procedures.

VI. OVERVIEW OF THE TRAINING FOR THE 15-MONTH LAB VISIT

Training for the 15-month lab visit will occur during February, 1992 in Madison, Wisconsin. This training will occur over three full days. Research assistants should arrive the night before the training.

Responsibility for training personnel to conduct the solitary play procedure is assumed by Sarah Friedman and Jay Belsky. Sue Spieker will train personnel on the Strange Situation. Marion O'Brien will oversee training on the Bayley. Deborah Vandell, chair of the 15-month lab visit, will oversee the coordination of the training session. Details of the training for individual components of the lab visit are detailed in their respective sections.

Appendix A. Lab Visit Log Form - 15 months

Appendix B. Lab Visit Monitory Form - 15 Months

Chapter 17

Section 2

PROCEDURES FOR OBSERVING AND CODING SOLITARY PLAY:

15-MONTH LABORATORY ASSESSMENT

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ACKNOWLEDGEMENTS

The solitary play procedure was developed by Jay Belsky taking into account suggestions from Sarah Friedman and Jean Gowen. Susan Spieker and Jean Gowen assisted in the selection of the toys. The coding of levels of play is based upon that developed by Belsky and Most (1981) who conducted a cross-sectional investigation of the development of play by studying children at 1 1/2 month intervals from age 7 1/2 to 21 months. The Belsky and Most (1981; Vondra & Belsky, 1991) system was based upon work carried out by a number of other researchers (e.g., Bates, 1979; Fein & Apfel, 1979; Fenson, Kagan, Kearsley & Zelazo, 1976; Fenson & Ramsey, 1980; Nicolich, 1977) and has been used extensively to study the development and exploration of play. The procedures for coding attention from tapes of the solitary play session were written by Sarah L. Friedman. These procedures are adapted from a study by Z. Breznitz and S. L. Friedman (Journal of Child Psychology and Psychiatry, 29, (3), pp. 267-279, 1988).

Chapter 17

Section 2

PROCEDURES FOR OBSERVING AND CODING SOLITARY PLAY:

15-MONTH LABORATORY ASSESSMENT

I. OVERVIEW

The purpose of this procedure is to obtain a sample of children's self-directed exploration/play in order to (a) scale the cognitive sophistication of the child's activity and (b) measure the child's attention to objects. Toward this end, each child will be presented with a set of play materials specifically chosen to permit a variety of play activities that can be scaled from less to more cognitively sophisticated. Children will be allowed to explore/play with these materials for a total of 10 minutes. Most 15-month-olds find the opportunity to explore these unfamiliar objects in a comfortable setting (i.e., mother present) very pleasant and have little difficulty remaining involved with the materials (though see trouble shooting later in this section).

Because Solitary Play is the first formal activity during the lab visit, it is used not only to observe children's play, but also to inform/remind mothers what the sequence of events of the entire lab session is and, more specifically, to outline what the next event, the Strange Situation, involves.

II. MATERIALS

The purchase of all play materials will be done by the Washington site or ordered by individual sites using suppliers and order lists supplied by the Washington site. One of these toys is a doll with "hair" that can sit up (and must be placed in the sitting position, facing the child). Each child will be presented with a doll that matches the child's gender and racial background. Since the sample composition in each site is known prior to the purchase of toys, each site will prepare all the dolls it needs in order to comply with the requirement to match dolls with children. If no doll representing the race of the child is commercially available, the child's mother will be consulted prior to entering the playroom and her wish regarding the race of the doll will be respected. The other toy items include a miniature bottle, miniature hair brush, miniature spoon, miniature bowl, miniature tea pot with lid, seashell, rectangular wooden block, one wooden clothespin (old fashioned, no springs), two colored sticks, one plastic "donut" (hole in middle) which sticks and clothes pins can fit through, Fisher-Price toy telephone (with dial and cord cut--so that receiver can be lifted to ear), irregularly shaped piece of washable tablecloth, miniature car or truck (that does not make sounds when pushed) with place for round-peg like people who fit in holes (as drivers), four toy people (that can fit into car or truck as drivers), toy horse, and toy cat.

III. PROCEDURES

After greeting the mother and making her feel at ease (as described in Chapter 17.1, III C), prepare the mother for the solitary play procedure and her involvement in it. The mother needs to be informed that she and her child will enter a room with a one way mirror and that she will be shown where to sit. The child will either sit in her lap or stand next to her until he/she gets interested in the toys that are placed on the floor in a semi-circle. Instruct the mother that when the child is ready she will lead the child to the center of the semi-circle and have him or her seated there. The mother is not to tell or suggest the child how to explore or play, even if the child brings a toy to show her. Should the child come to the mother to share a toy the visit coordinator will instruct the mother how to behave, always reminding her about not making specific suggestions. Specific suggestions to be avoided include naming the toys, telling the child how to use them or asking the child what he or she is going to do with a toy. If the child moves around so that his/her body and face are not facing the mirror, the visit coordinator will instruct the mother to reposition the child.

Following these preliminary instructions, the visit coordinator will check with the mother to see if the child is in need of a diaper change. If necessary, the child will be changed. If not, the visit coordinator will lead the mother and child into Playroom A.

This playroom should have virtually all possible interesting distractions removed. This means that garbage pails and other things on floors should be moved. This also means that interesting drawings be out of reach or behind barriers or that other efforts be made to keep distractions out of view of the child.

Toys should be arrayed in a semi-circle in such a way that there are spaces of an adult's hand width between objects that are not a part of a natural set. Toys that are part of a natural set, e.g. tea pot, bowl and spoon, should be placed in virtual contact with each other but the child should still be able to see each toy when the child is sitting at the center of the semi-circle of toys. When sitting at the center of the semi-circle the child should be able to reach all the toys either by extending the hand or by leaning forward to reach the toys at the extreme right or left of the semi-circle.

The mother's chair should be positioned no more than two feet away from the toy closest to it. The chair should be positioned so that the mother faces the visit coordinator and her back is facing the wall behind the video camera. With this arrangement, the mother's face can be seen by the child when the child, who is seated in the center of the semi-circle of toys, lifts his/her head to look in the direction of the mother's chair. The visit coordinator's chair should be positioned so that the child would have to move his/her head or body around, if the child would want to see the coordinator's face. See Figure 1

for room and toy set up instructions.

On the way to the room, the visit coordinator informed the mother that she would like the mother to hold her child on her lap until the child indicates that he/she wants to get down and play with the toys that are already arranged on the floor in a standard manner. When the child wants to get down, the mother should take the child and seat him or her down in the center of the semi-circle. It is important to let mother know that her job is simply to talk with the visit coordinator and not interact with the child anymore than is necessary.

Once in Playroom A, if the child is immediately ready to leave his/her mother's lap to play with the toys, let the child do so. Otherwise give the child time to feel comfortable in the room, notice the toys and become curious about them. If after a minute or two the child has not left the mother's lap, then the visit coordinator should interrupt her comments to mother (see below) and draw the child's attention to the toys by saying his/her name, making eye contact with the child and then just tapping with her finger on a few of the toys. This is all the visit coordinator should do with the toys. The visit coordinator should be sure not to manipulate any toy in a manner which reveals how it works. Having engaged in such attention-focussing behavior, the visit coordinator should continue with her comments to the mother. If, after 2-3 additional minutes, the child has

FIGURE 1

not moved off the mother's lap, the visit coordinator should repeat her attention-focussing behavior. If, after another 2-3 minutes, the child has not moved from the mother's lap to the toys, follow directions outlined in the Trouble Shooting section (#2). The play session will be officially started at the time the child is seated on the floor and will be terminated 10 minutes later.

Once the mother sits down on her chair, the visit coordinator should begin to explain to the mother in greater detail than before, what will happen during this activity and the next one.

He/she should say something like:

"While CHILD plays for the next 10 minutes, I will explain to you what we will do and what will happen for the rest of your time here today. Before I get started describing the visit's activities I want to tell you again how we would like to handle this play session. Our goal is to enable CHILD to play ON HIS/HER OWN with the materials that I have set out, without either of us naming them or suggesting toys for him/her to play with or things to do with them. There will likely be times when he/she looks up to you, shows you a toy, comes over to you or otherwise seeks your attention. What we want you to do is respond to him/her in a way that let's him/her know that you are here and interested in what he/she is doing, without doing anything to encourage his/her focus upon you rather than the toys.

I'll try to help you. When I see CHILD wants to show you something I will say something like 'just smile and tell him that it is nice;' If I see him/her come over to you, I will tell you just to lean forward, take what he/she has to offer, and then put it back on the floor beside the other toys. I may ask you to just lean over and give him a pat if it seems like he wants something more; and if he is persistent in his visits to your side, I may even suggest you pick him up for a little bit and then put him back down by the toys. Please feel relaxed and comfortable. What I would like for us to aim for is a situation in which the two of us are talking as CHILD plays at our feet. Before I go on to talk about the rest of the session, do you have any questions at this point?"

Most children will remain focussed upon the toys for the full 10 minutes. Strategies for re-focussing them if they do not are detailed below (see Troubleshooting).

Once the mother's questions are answered (if there are any), the visit coordinator should continue with her outline of the full sessions's events while continuously monitoring the child's position and activity. The visit coordinator should not neglect to monitor the child and the mother for the sake of conveying information about the "comings and goings" procedure.

"Now let's talk about what else we'll be doing today. You can look at the poster labelled "Playroom Activities" (see Figure 2) as I tell you briefly about what we have planned.

Please feel free to interrupt me at any time if there is something you do not understand or are curious about. After this toy session ends, we will go to another playroom. In that playroom I will leave while CHILD has a set of activities involving an unfamiliar adult coming to be with you and CHILD. I will explain more about this in a moment. After that activity is completed, we will take a break for a snack. Once the snack is over, I will return to ask CHILD to do some interesting structured activities with objects. During this time, we will want you to be by CHILD's side or have him/her on your lap. But again, don't worry about your role, as I will tell you what we would like you to do. In the last activity of the day we will be weighing and measuring CHILD.

Now let me tell you some more about the next major activity we have planned, the one labelled on the second poster as "Comings and Goings." The purpose of "Comings and Goings" is to see how CHILD responds to an unfamiliar person and the comings and goings of you and this person. Please don't worry about memorizing any of this, as I will guide you all the way. As you can see from the second poster, the first thing that will happen is that I will take you to another play room. You will lead CHILD into the room and show him/her a new set of toys. You will then sit in a chair that I point out to you. Shortly after you and CHILD are settled, NAME OF STRANGER will join you and

sit in the other available chair. For a minute she will sit quietly; for another minute she will chat with you; and finally, for another minute she will try to interact with CHILD. At the end of this 3-minute period, NAME OF STRANGER will nod to you when it is time to go into the observation room. What we would like you to do then is just pick yourself up and leave the room so that CHILD and STRANGER can be together. Leave your purse behind. I will then take you into the observation booth next door so you can see all that happens while you are gone.

You will be out of the playroom for 3 minutes unless CHILD cries. Then we will send you right back. You'll pause before you greet CHILD, then do what seems natural under the circumstances. Get your child to return to play and you go to your chair. When you hear a knock after about 3 minutes, you'll get up, go to the door, say "bye-bye" and come back into the observation room. Again, leave your purse behind. If CHILD cries, we will send STRANGER in to try to comfort him/her. If he/she doesn't get upset, STRANGER will go in after 3 minutes.

After 3 more minutes (sooner if CHILD cries), you will go back in. Pause a moment to see what he does, then greet him.

Figure 2

POSTER 1

PLAYROOM ACTIVITIES

1. Play with Toys
2. Comings and Goings
3. Snack
4. Structured Activities
5. Growth Measures

POSTER 2

COMINGS AND GOINGS

1. Baby plays, mother sits
2. New Adult enters
3. New Adult nods, mother leaves quickly
4. Mother returns, pauses, goes to chair
5. At the knock, mother leaves, says bye bye
6. New adult returns
7. Mother returns, pauses, picks up child,
goes to chair

Then, even if CHILD does not seem to need it, pick him up and do what seems natural under the circumstances. As before, we want him to play and you to return to your chair. After 3 more minutes, we'll take a break for a snack. Now, don't worry about remembering all this. I will remind you as we go along. There'll also be a poster on the wall in the other playroom to tell you what to do.

Now that I have gone through the whole visit, do you have any questions?

At this time the visit coordinator will initiate informal conversation with the mother, inquiring about the child, his or her siblings, family activities or other topics of small talk. Be sure to have topics ready and avoid periods of silence.

A. Videotaping Solitary Play

In order to code the videotape for sustained attention and levels of play, it is necessary to see on the screen the child's face, body, and hands as well as any objects that are being manipulated. Consequently, the camera person should adjust the zoom lens so that all of these components are captured by the camera simultaneously. The video image should also include the date and time (to the nearest second). The visit coordinator needs to know which parts of the room cannot be captured by the camera and try to get the child away from these blind spots.

IV. TROUBLESHOOTING

The most important thing to remember throughout this procedure is that the visit coordinator is free to converse with mother to help facilitate the goal of keeping the child involved in play. Ultimately, our goal is to create a situation that is both familiar and comfortable, resembling something that might happen at the child's home: mother conversing with a friend and child playing at her feet. Despite the best efforts, problems can arise that undermine the procedure.

1. Child Just Sits and Looks: A child may be apprehensive about engaging with the play materials and may just sit and look at the mother or visit coordinator. If this occurs for 30-60 sec., the visit coordinator should get up from her seat and proceed to tap on several of the toys simply to draw the child's attention to them. It is most important that the visit coordinator not move or manipulate the object in some way that reveals a unique property (e.g., spin wheels on toy), as this is something we will be measuring and if it occurs we want it to be initiated by the child.

If the child is not enticed by the tapping on the toys and continues to just sit and look for another minute or two, the visit coordinator will invite the mother to sit on the floor either behind the child or with the child in her lap. The visit coordinator will reposition herself so she can continue to talk to the mother without obstructing the view for the camera or making the child uneasy.

2. Child Won't Separate from Mother: Sometimes the child does not want to separate from the mother. It is important not to force the child to separate from the mother, because the whole procedure is predicated upon making the child comfortable. Thus, be alert to mothers who, for whatever reason, are inclined to over encourage their child to get down on the floor and play. If, after the visit coordinator taps on several toys, the child still will not separate, direct the mother to get down on the floor with the child. Tell her she can set the child in front of her or she can have the child sit on her lap. If this happens, the visit coordinator will need to reposition herself so that she can look at the mother, but don't move in a way or to a place that is going to add to the child's uneasiness. It is most important for the visit coordinator, in this and all situations, to maintain a friendly, easy exchange with the mother in hopes of putting the child at ease. In this particular situation, the visit coordinator will need to remind the mother that she is not to play with the child.

3. Child Won't Play: On rare occasions a child is sufficiently uncomfortable that he/she will not play, even with the mother sitting on floor nearby. The reason may be that the child is simply too inhibited by the other adult's presence. If this occurs for a minute or two, the visit coordinator should leave the room. Before departing, explain to the mother that children are sometimes uncomfortable in the presence of strangers, so this is the reason he/she is going to leave. BE

SURE TO REMIND THE PARENT OF THE ROLE SHE IS TO PLAY--MINIMALLY RESPONSIVE, NONPARTICIPATORY, WITHOUT PROVIDING DIRECTIONS AND SUGGESTIONS FOR PLAY.

4. Child's back to the camera: The visit coordinator will continuously monitor the child's position and evaluate its relationship to the camera. If the child sits with her or his back to the camera for 30 seconds, the mother will be instructed to gently reposition the child while allowing the child to continue playing with the same object(s). In the case of a child who is mobile and constantly moving around there is no point in repositioning the child.

5. Child Goes Over to Mother: Sometimes children will interrupt their play to go to see mother. It is our goal to have the child be engaged with toys for as long as possible and thus not encourage mother-child interaction. To achieve this goal, however, the visit coordinator needs to be sensitive and responsive to the child's needs and desires. Thus, when a child gets up to approach the mother, try to anticipate this and remind mother what to do. Tell her just to lean over and hug the child if this seems to be all the child wants. If more seems to be needed tell the mother to pick the child up and hold him on her lap for a few moments. When you judge the baby to be at ease tell the mother that she can put the baby back down. Usually 30-45 seconds is more than enough.

6. Mother Telling/Showing Child What To Do. Despite initial directions to the mother about not showing or suggesting

behaviors to children, some mothers will do otherwise (mostly inadvertently). The visit coordinator will need to carefully monitor the mother's input and courteously interrupt her if she starts to give specific play directives. The best way to do this is to simply say "remember we want you to just direct the child towards the toys in general and not offer any specific instructions."

7. Child Wanders Away, But Not Toward Mother. Some children, when they lose interest in the toys, will leave the toy play area or come over to the mirror or to the visit coordinator for more than a minute or two. In such instances the visit coordinator should go over to the toys, call the child's name, and then tap on several of the toys in an effort to draw the child's attention back to the play objects. If the child does not come back to the materials on his own, the mother would be instructed to pick up the child and bring him back to the toys, again placing him/her in a seated position facing the playthings.

8. Child Repeatedly Wanders Away. Some children will lose interest in the toys repeatedly. If the child approaches the mother or wanders away more than 5 times and cannot be refocussed except for fleeting periods of time, the session should be terminated.

9. Interruptions. Unanticipated interruptions can occur, for example, if the baby needs a diaper change (try to do these before child gets started playing, if possible) or starts to cry for some reason. In such cases simply make the necessary

adjustments (e.g., change diaper, comfort child) and then pick up the play session once the child is ready to go again. Seek to obtain a full 10 minutes of play, despite the interruption (e.g., 7 minutes before, 3 minutes after). Only if the child wanders repeatedly and cannot be refocussed should a session be terminated before a full 10 minutes.

10. Security Objects. Some children will come to the play session with some kind of security object (e.g., blanket, doll). Ideally we would like the child to leave such objects with the stroller/diaper bag in the storage office and not have them down on the floor with the child, but not at the cost of the child being so uncomfortable that he/she will not play. Thus, ask the mother to take the object in question away from the child, but let her know that if the child will seriously protest, we will not insist on it. Be ready to direct the mother not to bother if it seems as if she may be too assertive in taking something away from the child and that this will upset the child. Pacifiers are acceptable in the playroom, if necessary. Bottles are not permitted unless absolutely required by the child.

V. TRAINING TO CONDUCT THE SOLITARY PLAY SESSIONS

Formal training on how to conduct the solitary play procedure is to be provided as part of the overall three day training for the 15-month lab visit to be conducted in Wisconsin in February, 1992. Prior to the formal training, RAs should study this manual. They should then videotape three pilot

sessions that are to be sent to Jay Belsky and Sarah Friedman at least one month prior to the training. These tapes will form a basis for discussions at the training meeting as to how a range of situations should be handled.

Major goals of the training are for RAs to be able (a) to create a comfortable atmosphere so that the child can play while his/her mother is engaged with the visit coordinator and (b) to know how to respond to situations that arise when the child is not playing with toys. The best way to insure that RAs attain these goals is for each of them to be videotaped with two to three children after the training to insure that they are "good at thinking on their feet". After training Jay Belsky and Sarah Friedman will coordinate this review.

VI. CODING METHODS: SUSTAINED ATTENTION

A. INTRODUCTION

For the purpose of this study, sustained attention is defined in terms of engagement with objects through exploration. Both visual and tactile exploration are coded. Usually, the coder's observation of visual attention guides the decision to code sustained attention since in sighted 15 months olds, tactile exploration rarely occurs without parallel visual attention. In other words, when the child looks intently at an object either with or without touching it, attention is coded. The coder waits for 2-3 seconds to verify that the attention to the object is not transitional.

The coding for sustained attention will follow procedures developed by Sarah L. Friedman (NICHD) with the assistance of Karen Livesey (NICHD) and Cheryl Edmonds (University of Washington). These procedures have grown out of procedures developed by Breznitz and Friedman (1988). The coding will be conducted at the University of Washington by Cheryl Edmonds and Tana Mason and will be monitored by Susan Spieker (on site) and by Sarah Friedman.

The coder will view tapes of solitary play and will code instances of sustained attention by talking into a microphone, which activates a computer program developed by Tim Myers of the University of Washington. The computer program was designed to store information about the identity of the child, the date of data collection, the coder, and the date of coding. It was also designed to store detailed information about the child's sustained attention and related behavior of the adults who monitor the child's attention.

The computer program can provide the investigators with the following information:

1. Latency from "mother sits" to the child's first touching of a play object.

2. Latency from "child sits in front of toys" to the first touch of a play object.
3. Length of available play time from the first toy touch to the end of the session.
4. The reason the session was shorter than the expected 10 minutes from first toy touch:
 - a. Technical;
 - b. Child lost interest.
5. Total time the child is engaged with anything (physical or social objects) in the environment. Duration is reported in seconds.
6. Total time the child is engaged with physical objects.
7. Total time the child is engaged with the play objects (toys) available in the room.
8. Number of different physical objects attended.
9. Average duration of first instances of sustained attention across physical objects.

10. Average duration of attention to physical objects that were attended to one at a time.
11. Average duration of attention to multiple physical objects.
12. Average number of social bids.
13. Average duration of attention to social objects.
14. Average duration of attention to a combination of social and physical objects.
15. Average number of adult attempts to refocus the child on toys.
16. Number of unoccupied bouts.
17. Total time spent unoccupied.

B. MATERIALS

The coder of attention during the solitary play session must have access to videotapes of the solitary play procedure and to the

coding equipment. The equipment consists of a videotape recorder, a monitor, and a computer equipped with the attention coding software.

The software allows the coder to first enter information about the coder's name or ID, the child's ID, the date at which the data was collected, the child's age at data collection and the date of coding. In addition, the software allows the computer to recognize the voice of the coder when she uses the limited lexicon needed for coding. The list of words recognized by the computer is as follows:

1. Block; 2. Bowl; 3. Bottle-miniature; 4. Hair-Brush; 5. Car; 6. Cat; 7. Cloth; 8. Clothespin; 9. Doll; 10. Doughnut; 11. Horse; 12. People; 13. Sea shell; 14. Spoon; 15. Stick-blue; 16. Stick-yellow; 17. Teapot; 18. Teapot-lid; 19. Telephone; 20. Telephone-receiver; 21. Other; 22. Social; 23. Scan; 24. Refocus; 25. Technical; 26. Unoccupied

C. CODING PROCEDURES

(i) An overview

Two master timers are started at the beginning of the session: one that keeps track of the total amount of any type of attention (including scan and social) and the other that tracks the amount

of time that the child is engaged with objects.

Since we are interested in the time it takes for children to begin playing in the solitary play session, three different times are recorded into the computer: 1) the time the mother is seated, 2) the time the child is seated on the floor, and 3) the time at which the child first touches a toy. These times are entered in the "tape time" fields of the computer program.

The coding of sustained attention begins in one of two ways: (1) when the child is seated in the semi-circle by the mother or (2) in the case of a child who is standing by the mother at the start of the session coding starts when the child is released from the mother's side. It is possible that the first code may not indicate attention to an object, if for example, the child first scans the room (coded as "scan") or returns to the mother (coded as "social"). The coder continues to code until the end of the session, usually 10 minutes following the child's first touching of one of the toys in the semi-circle. The coder is observing the child and the solitary play environment with the intent to code the following occurrences:

The child is playing with one or more of the 20 toys in the semi-circle (see list above). The child is exploring visually and/or touching other objects in the room (e.g. door knobs, window, heating vent). The child is interacting with the

mother or the experimenter (e.g. talking to, showing objects, touching). The child is scanning the room, looking for play opportunities. The child is unoccupied (e.g. not interested, sleeping, or crying). The child is straying out of sight or turning his/her back to the camera. The child is being encouraged by the experimenter or the mother to refocus on the toys.

As mentioned earlier, for the purpose of coding attention in this study, sustained attention is defined in terms of visual and tactile exploration of physical and social objects. Consequently, when a child manipulates objects in a stereotypical fashion (repetitive, mindless manipulations) and is looking elsewhere, attention is not coded.

Attention is coded when the child explores one object at a time as well as when the child explores several objects simultaneously. When a child is uninvolved with the external environment, no code of focused attention is entered. Rather, the coder notes that the child is unoccupied.

(ii) The Units

The child has twenty toys available to him or her. In addition, there are objects that are part of the playroom environment and

two adults that are engaged in a conversation. These physical and social objects can be engaged with individually or in different combinations.

There are 3 toy objects that can be coded in two different ways, depending on the circumstances: The telephone and the teapot.

1. The unit "Telephone" is coded when a child attends to the receiver and the base as they appear together at the start of the session (receiver on top of the telephone) or when the two components are in very close proximity to each other. When a child plays with the base of the telephone only, the unit "telephone" is also coded. The "telephone-receiver" code is used when a child plays with the receiver away from the telephone base.

(Clarification: the telephone receiver has an object in it which makes a noise when it is shaken by the child. Consequently, children shake the receiver to explore the sound and this is different from just holding an object or engaging in stereotypical behavior. Therefore, this action should be coded as an instance of attention.)

2. "Teapot" is coded when a child attends to the teapot and lid as they appear together at the start of the session (lid is on top of the teapot) or when the two components are in very close proximity to each other. When a child plays with only the body of the teapot, the "teapot" code is used. The "teapot-lid"

code is used when a child plays with the lid away from the pot.

3. "Car" and "people" are both coded when the child puts the people into the car or when the child plays with them as separate objects (putting the people in and then taking them out of the car). The people should be turned off when the child starts to move the car around (with the people inside).

When a child plays with objects other than the toys provided, this is noted as "other". Objects subsumed under the "other" category include door knobs, windows, curtains, carpet, posters, their own clothing, mirrors, etc.

When a child looks at, approaches or interacts with the mother or the experimenter (visit coordinator), a "social" code is entered. However, if a child stands near or leans against the adult but does not look at her or interact with her, no code of sustained attention is entered. "Social" is coded when the child looks in the direction of the mother or the VC for more than 2-3 seconds (Short social referencing is not coded.). The "social" code can be used in combination with "toy" and the "other" code. When the child hands the mother a toy that is not already turned on, both the "toy" and "social" should be coded. When the child approaches the mother for attention, the "social" code should be used. But once the child is sitting on the mother's lap, looking at other objects, the coder should code what the child is attending to and

ignore the fact that the child is sitting on the mother's lap. Therefore, the "social" code is turned off once the child stops paying attention to the mother and starts to attend to other objects. There will be times in which the child repeatedly hands toys to the mother. In such cases, the code for the toy being handed to the mother should be turned on as soon as the child picks up the toy. The "social" code should be turned on when the child hands the toy to the mother. Both codes should be left on as the mother places the toys on the floor. Then, if the child picks up the toys in three or fewer seconds, leave both codes on. If, however, the child does not pick the toys back up in three or fewer seconds, both codes should be turned off.

When a child is actively looking around the room, either while sitting or walking, a "scan" code is entered. When the "scan" code is activated, no other code can be active at the same time.

When a child is not engaged with the environment, the experimenter intervenes and attempts to refocus the child by tapping the tops of toys or by instructing the mother to act in a way that might refocus the child. When one of the two adults is attempting to refocus the child, the "refocus" code is entered. When the "refocus" status is active, no other code can be active at the same time.

When a child strays out of the view of the camera so that direct observation is impossible, a "technical" code is coded. Technical is also coded when the child's back is to the camera and it is not possible to see what the child is doing. However, if the coder can tell from the child's posture, movements, or position of the child's head what the child is doing, it is appropriate to code that behavior. As soon as the coder is uncertain what the child is doing, "technical" should be coded. During this status, the 10 minute timer is suspended until normal coding can resume. When the "technical" code is active, no other code can be entered.

If the child cries, sits without visually exploring or falls asleep, the "unoccupied" status is noted. When the "unoccupied" code is active, no other code can be entered at the same time. Unoccupied behaviors will also include behaviors in which the child is not involved in exploring the environment in a positive manner. When it is unclear whether or not the child is scanning the environment, code as "unoccupied". For example, if a child is sitting on the mother's lap, looking around the room, but not actively scanning the environment, code "unoccupied".

(iii) The act of coding

The first step in coding attention is to train the computer program to recognize the voice of the coder before a specific

coding session begins. The program is very sensitive to variations in voice and intonation and may not recognize the same coder from one day to the next.

The next step involves providing the computer program with information such as the child's i.d., the time the mother entered the room with her child and the time she sits in her chair. All the child's acts of sustained attention as well as the adults' attempts to focus the child are noted by saying out the name of the event, using the words spelled out above (Under "the units"). Saying the name activates a timer in the computer program. To deactivate the timer, the coder says the name of the same unit again. The coder deactivates the timer that is associated with a given category when the child finishes attending to that category. The computer program allows parallel timers to be activated. So, by mentioning one unit and then another, the computer accumulates a record of simultaneous events. Different combinations of events can be recorded with this system. The coder has to be very alert to capture the multiple, simultaneous events with their initiation and termination. The task is made less daunting by allowing for a 2-3 second delay when making coding decisions. For the purpose of this study we do not need information about fleeting instances of attention to the environment.

Real data tapes that the coder finds difficult to code will be

viewed as many times as it takes to comfortably capture the attention events. Once the coder feels that she or he have resolved the difficulty, the tape is coded again.

D. TRAINING OF 15 MONTH ATTENTION CODERS

Cheryl Edmonds was trained by Sarah Friedman to be the lead coder. The lead coder followed a set of written procedures developed by the attention coding team: Sarah Friedman, Susan Spieker, and Cheryl Edmonds. This set of procedures provided guidance and structure to the method of evaluating attention in 15 month olds. In the event the procedures were not clear about an attention status, conversation and viewing the behavior in question ensued with Sarah and a decision was reached; this coding decision was adopted and integrated into the procedures. During this initial phase, the lead coder dubbed voice coding onto video tape with the subject; these voice-over tapes were shared with Sarah and Karen Livesey for review and approval.

After several dozen practice coding sessions, the lead coder identified 6 subjects to be used for certification of coders. These 6 subjects were pilot subjects. The 6 subjects consisted of 4 very active children and 2 more passive children--3 boys and 3 girls. The lead coder coded these subjects with voice-over, and the results including the computer print out were reviewed by Sarah for the purpose of certifying the lead coder. After Sarah

provided feedback and adjustments were made, the lead coder was certified for coding.

Once certified, the lead coder trained additional coders. All coders new to the team were given an orientation by the lead coder that included familiarization of the written procedures and viewing of pilot subjects. This was followed by an overview of the computer process including voice training, DOS, coding software, and data management. After the procedures were read and questions answered, a demonstration of the coding process was performed by the lead coder. Following this demonstration, the new coders practiced on 6 pre-selected subjects (not the certification subjects); the results of the coding were compared for accuracy with adjustments made for fine tuning.

E. CERTIFICATION AND RELIABILITY

After a new coder completed the training described above and the lead coder judged the coder ready to progress, s/he was required to code 6 tapes of pilot subjects for certification. These were the same 6 tapes on which the lead coder had been certified. The tapes were of 3 boys and 3 girls with a ratio of 2:1 of active to non-active boys and girls. Certification was based on the reliability scores of pairs of coders who coded these 6 tapes.

Reliability was calculated at the Data Analysis Center at

Vanderbilt University and reviewed by Sarah for final approval. Reliability was calculated using intraclass correlations (Bartko, 1976; Bartko & Carpenter, 1976; Shrout & Fleiss, 1979). Behavior variables that were coded fell into two categories, durations and frequencies. The criterion for reliability was different for each type of variable. Duration variables were required to have a reliability level equal or greater than .75. Frequency variables were required to have a reliability level equal or greater than .60. Sarah reviewed the reliability results and made final decisions on certification. If the reliability between coders was below the standard, sources of difficulty were discussed and additional practice tapes were coded if necessary.

After a coder had been certified, the coding of real subjects began. During the process of coding real subjects, every 20th tape was coded for reliability. These data were sent to the Data Analysis Center at Vanderbilt University for reliability calculation. These data were also sent to Sarah along with voice-over tapes for her review. The lead coder monitored these reliability checks. Any variable that did not reach the criterion for reliability was scrutinized so that the coding scheme could be more finely tuned.

As an additional tool to evaluate and monitor performance, the lead coder graphed the coding results of subjects coded for reliability by individual variables. This provided graphic

at-a-glance information for the coders to check their concurrence on raw data.

F. SELECTING SUBJECTS TO CODE

There was a prescribed manner for selecting subjects to be coded. Approximately 35 subjects at a time were selected from each site. Once a subset of subjects from one site was coded, the coder moved onto another site and coded approximately 35 more subjects. This continued until a subset from each site had been coded. The coder continued to make this cycle until all subjects had been coded. A site was never totally coded in one pass or time frame. It took about 4 cycles to complete coding at a site. All the solitary play tapes videotaped when the children were 15 months old were coded over an 8 month period.

VII. CODING METHODS: LEVELS OF PLAY

A 14-step system will be used for coding the cognitive sophistication of toddler exploration and play. The defining features of each level of play is detailed in Table 1. This system is based upon that developed by Belsky & Most (1981) who conducted a cross-sectional investigation of the development of play by studying children at 1 1/2 month intervals from age 7 1/2 to 21 months. This 14-level scoring system can be reduced further to 5- and 3-level systems by collapsing several levels of play into higher-order play tiers (see Table 2). The 3-level

scoring system is based upon findings of Belsky & Most (1981) indicating that the three levels evinced quite different developmental trends.

The coding of solitary play will be done by Susan Spieker and staff at the University of Washington. The coder watches the videotape of the child's play and, after every 15-seconds of observation, makes several quick judgements. The coder records the highest level of play that the child engaged in. Then, the coder records whether any play act at or above the level of functional play was observed for the first time.

With regard to scoring play, it is important to recognize that children can be motorically limited in their ability to manipulate objects skillfully. What is being coded is evidence that the child knows how things can go together and provides behavioral indication of such. For example, a child trying to put the lid on the teapot should be credited with a functional

TABLE 1

14-LEVEL OF PLAY CODING SYSTEM

1. **Mouthing**--indiscriminate mouthing of materials (e.g., peg, seashell)
2. **Simple manipulation**--visually guided manipulation (excluding indiscriminate banging and shaking) at least 5 sec in duration that cannot be coded in any other category (e.g., turn over an object, touch and look at an object)
3. **Functional**--visually guided manipulation that is particularly appropriate for a certain object and involves the intentional extraction of some unique piece of information (e.g., turn dial on toy phone, squeeze piece of foam rubber, flip antenna of Buzy Bee toy, spin wheels on cart, roll cart on wheels)
4. **Relational**--bringing together and integrating two or more materials in an inappropriate manner, that is, a manner not initially intended by the manufacturer (e.g., set cradle on phone, touch spoon to stick)
5. **Functional-relational**--bringing together and integrating two objects in an appropriate manner, that is, in a manner intended by the manufacturer (e.g., set cup on saucer, place peg in hole of pegboard, mount spool on shaft of cart)
6. **Enactive naming**--approximate pretense activity but without confirming evidence of actual pretense behavior (e.g., touch cup to lip without making drinking sounds, tilting head back, or tipping cup; raise phone receiver in proximate of ear without making talking sounds; touch brush to doll's hair without making combing motions)
7. **Pretend self**--pretense behavior directed toward self in which pretense is apparent (e.g., raise cup to lip; tip cup, make drinking sounds, or tilt head; stroke own hair with miniature brush; raise phone receiver to ear and vocalize)
8. **Pretent other**--pretense behavior directed away from child toward other (e.g., feed doll with spoon, bottle, or cup; brush doll's hair; push car on floor and make car noise)
9. **Substitution self**--using a "meaningless" object in a creative or imaginative manner in activities directed toward self (e.g., drink from seashell) or using an object in a pretense act in a way that differs from how it was previously used by the child (e.g., use hairbrush to brush teeth after already using it as a hairbrush on self or other)
10. **Substitution other**--same as level 9, but action is directed toward agent other than self, typically doll or mother.

TABLE 2
LEVELS OF PLAY SCORING SYSTEM

Systems:

<u>3-Level</u>	<u>5-Level</u>	<u>14-Level</u>
Undifferentiated Exploration	Undifferentiated Exploration	1. Mouthing
		2. Simple Manipulation
	Functional	3. Functional
Transitional Play	Transitional Play	4. Relational
		5. Functional- Relational
		6. Enactive Names
	Simple Pretend	7. Pretend Self
		8. Pretend Other (doll, cat, horse, parent, visit coordinator)
Symbolic Play		9. Substitution Self
	Elaborated	10. Substitution Other
	Pretend	11. Sequence No Story
		12. Sequence Story
		13. Sequence Substitution
		14. Double Substitution

relational act even if he does not completely succeed in getting the lid on the pot. The coder has to be confident, though, that the child was not simply juxtaposing one entity to another (thus code "relational") but recognized and was pursuing a particular relation between lid and pot.

Often times a child needs to provide "collateral evidence" that his/her behavior is as cognitively sophisticated as it might be judged to be. For example, the placement of a spoon into a teapot is not coded as "pretend other" unless there is clear movement of the spoon in the teapot to convey stirring or unless the spoon or pot is then brought to the mouth (in which case a sequence pretend would be recorded). Similarly, rolling a car across the floor is coded simply as "functional" unless accompanied by motor noises which indicate that the child knows the toy is a car. Similarly, for use of the telephone to be coded as pretense, the child must make sounds of some sort with the receiver (as if talking) or dial before raising the receiver to his/her head, or hang up soon after juxtaposing the receiver to his/her head. Sometimes toddlers will simply raise the receiver someplace above their shoulder. This is scored as "inactive naming" unless accompanied by babbling sounds; in such cases, even if far from the head, this is coded as pretense.

By recording this information on special forms (see Appendix) following each 15-second epoch, a series of scores can be generated. These will need to be pro-rated to reflect a 10-minute play period in the case of children whose play session

was terminated early (see Section 17.1).

Variables to be generated by this code are:

1. Mean Level of Play--Using either the 3-, 5- or 14-level scoring system, the average level of play observed across the sampling periods.

2. Diversity of Play--the total unique play acts that the child engaged in. This score can be calculated by summing across all levels of play at and above functional, or by creating diversity scores using the 3- and 5-level scoring system.

VIII. TRAINING AND RELIABILITY FOR THE CODING LEVELS OF PLAY

Training for levels of play will proceed through a series of training steps.

A. Familiarity

Coder trainees will read scholarly material on the development and coding of play (including scoring manual provided by Jay Belsky) before watching the pre-coded tapes. Questions regarding these codings will be compiled, as will play segments that are confusing, and these will be reviewed when Jay Belsky visits Seattle to conduct formal training.

B. Formal Training

During the 1-1/2 day visit to Seattle, Jay Belsky will formally train coders. First he will review confusions raised by the "familiarity" tapes. Then he will review and code with the trainees new tapes that have not been seen before.

C. Reliability Testing

Before initiating formal coding, each coder-to-be will code 5 tapes. One month after passing this test (and coding real data), coders will take a second reliability test on 5 tapes every 3 months. Thereafter a repeat test on 3 new tapes will be conducted.

IX. APPENDIX

A. Attention Coding Sheet

B. Levels of Play Coding Sheets

C. Unique Play Acts Recording Form

CHAPTER 17

SECTION 3

OPERATIONS MANUAL FOR THE STRANGE SITUATION

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CHAPTER 17

SECTION 3

OPERATIONS MANUAL FOR THE STRANGE SITUATION

I. OVERVIEW

A. Introductory Comments

This chapter concerning the Strange Situation contains extensive excerpts from Ainsworth, Blehar, Waters, and Wall's (1978) Patterns of Attachment. The annotations that accompany the text are based on guidelines that have developed in many laboratories in over 20 years of Strange Situation research.

The Strange Situation consists of eight episodes presented in a standard order for all subjects, with those expected to be least stressful occurring first. After a brief introductory episode, the baby was observed with his mother in the unfamiliar, but not otherwise threatening environment of the experimental room, to see how readily he would move farther away from her to explore a novel assembly of toys. While the mother was still present, a stranger entered and made a very gradual approach to the baby. Only after this did the mother leave, because it was anticipated that separation from her would constitute a greater stress than the presence of a stranger and/or of an unfamiliar environment per se. After a few minutes the mother returned and the stranger slipped out. The mother was instructed to interest her baby in the toys again, in the hope of restoring his exploratory behavior to the baseline level characteristic of when he was previously alone with his mother. Then followed a second separation, and this time the baby was left alone in the unfamiliar environment. As some check on whether any increased distress was a response to being alone rather than to having been separated a second time, and also to ascertain whether separation was more distressing than the presence of a stranger, the stranger returned before the mother finally returned.

There are undoubtedly other sequences of episodes that would be interesting to study, and there may be others that

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There are undoubtedly other sequences of episodes that would be interesting to study, and there may be others that

would have been equally or more effective in evoking the responses for which the situation was designed. But as it turned out, the sequence just summarized was very powerful both in eliciting the expected behaviors and in highlighting individual differences. The sequence of episodes is described in more detail as we proceed (pp. 32-33).

Table 1 briefly outlines the 8 episodes of the Strange Situation. The learner should become familiar with this table before reading further in this manual. The Strange Situation procedure must be followed very carefully. It is important that the Visit Coordinator be familiar with the rationale underlying both the procedure and the way that it is coded. This will enable the Visit Coordinator to direct the behavior of the mother, Stranger, and Camera Operator, and make informed decisions about when curtailing or pausing the procedure is necessary. If the procedure is conducted poorly, the assessment will not be valid and cannot be coded. In that case we would either have missing data, or we would have to conduct a second assessment 6 to 8 weeks after the first.

Solitary Play will be conducted before the Strange Situation in a different room. While the child is engaged in Solitary Play, the Visit Coordinator will tell the mother about the remaining Strange Situation procedures. When the Visit Coordinator calls the mother the evening before the visit, the Visit Coordinator should ascertain that the child is currently healthy and has not had any unusual separations from the mother in the previous week (See page 6 of Section 17.1). An unusual separation would be mother or child away from home for a night.

TABLE 1

**Summary of Eight Episodes of the Strange Situation
for the NICHD Study of Early Child Care**

Number of Episode	Persons Present	Duration	Brief Description of Action
1	Mother, Child, 30 sec & Visit Coordinator	30 sec	Visit Coordinator introduces mother and child to play room.
2	Mother & child	3 min.	Child is led into the room and allowed to approach toys. Mother sits in her chair. Child explores.
3	Stranger, mother, & child	3 min.	Stranger enters. First minute: Stranger silent. Second minute: Stranger converses with mother. Third minute: Stranger approaches child. After 3 minutes mother leaves unobtrusively.
4	Stranger & child	3 min. or less ^b	First separation episode. Strangers's behavior is geared to that of child.
5	Mother & child	3 min. or more ^c	First reunion episode. Mother greetes and/or comforts child, then tries to settle him/her again in play. Returns to her chair. Stranger leaves after child is playing. Mother leaves after 3 min. or at end of episode (Knock on door), saying "bye-bye."
6	Child alone	3 min. or less ^b	Second separation episode.
7	Stranger & child	3 min. or less ^b	Continuation of second separation. Stranger enters and gears her behavior to that of child.
8	Mother & child	3 min.	Second reunion episode. Mother enters, greetes child, then picks him/her up. Mean-while Stranger leaves unobtrusively. Mother eventually returns to her chair

aFrom Ainsworth, et al., p. 37.

bEpisode is curtailed if the baby is unduly distressed.

cEpisode is prolonged if more time is required for the baby to become
reinvolved in play.

Remember that no matter how well the Strange Situation is run, the quality of the videorecording is the ultimate determiner of the quality of the data. Camera directions will be discussed in a later section. For the Strange Situation, the camera should always remain focussed on the child; therefore much of the mother's behavior will occur off-camera.

For this procedure, it is important that nothing happen in the room or off-camera (but visible to the child) that is odd or unusual. For instance, the mother should not enter through a door, pass along a wall, and step over a low room divider before gaining proximity to the child. The episode cannot be filmed by a camera in the room. The mother should not leave through one door and return via another.

II. THE PHYSICAL SITUATION

Two rooms will be needed to conduct the Strange Situation: playroom B and a camera/observation room. The videotaping should be done through a one-way observation window built into the wall between the two rooms. There are many configurations that will work for the set-up of the playroom, and many that will not. The basic principles to consider are discussed below. We understand that it will be necessary to work with sites individually to design the best set-up possible within the constraints posed by unique site conditions.

The playroom should have; 9' X 9' or 8' X 10' of clear floor space. A larger room is better than a smaller one. Chairs and

other furniture must be located outside this perimeter. The room should be carpeted, cheerful, and comfortable. If the room is not carpeted, buy a rug, that fills most of the room, that will not slide or bunch up under the child when she walks or crawls. A throw rug or blanket will not do. If there is an outside window, it must be curtained so that there is no glare for the camera. The playroom may have some pictures on the walls. Think of it as a simple, cheerful waiting room. Do not use knickknacks or items that the mother will have to monitor or prohibit the child from exploring. There should be a simple chair for the Stranger in one corner and a simple chair for the mother in another corner. In the child's area there should be a variety of attractive toys. Think of the child's area as the apex of a triangle with the mother and the Stranger located at the other two points. The toys must be at least 5 feet from the door, and further than that if possible.

There should be a designated door through which the mother and the Stranger will depart and return. The Stranger should try not to walk between the camera and the mother, between the camera and the child, or between the mother and the child. The Stranger must never sit in the mother's chair.

The door, ideally, should open so that the camera's view of reunions is never obscured by an open door. In most cases, this means that the door should open outward, into the adjoining space. Fortunately, since it is difficult to re-hang doors, the problem of an inward-opening door can be alleviated by the

Stranger's behavior. The Stranger must keep the child away from the door so that child's behavior at the moment of reunion can be recorded.

Figure 1 is a sketch of the room set-up used in Ainsworth et al. (1978). Note that Ainsworth used Observers, not a camera, to record notes on the assessment. This arrangement would give the camera a front or 3/4 view of the child when the child approaches the Stranger's or the mother's chairs, and a rear view when the child approaches the toys. At best, there is a profile view of the child when the child orients to the door and a person entering it. Note how the door opens inward. If the child is at the door, he/she could be difficult to see at the moment of reunion.

Figure 2 depicts another arrangement that we have used with good success in Seattle. In this set-up, the child's back or profile (at best) is seen when approaching the mother's or Stranger's chairs. A profile to 3/4 view is seen as the child orients to the door and someone entering. The door opens inward, which is not ideal. In this case, however, a child sitting right at the door and looking up as the mother enters can still be seen at least in profile. It would have been more problematic if the hinges had been on the other side.

There are obviously trade-offs when designing the set-up of the playroom relative to the door and the camera. It is important to remember that the most important moments in coding

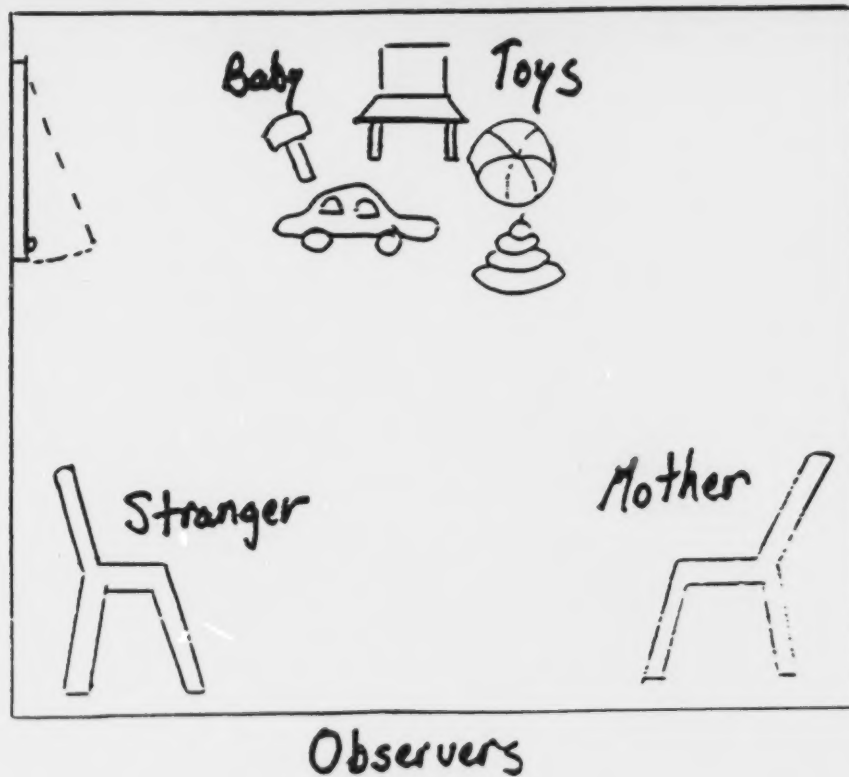
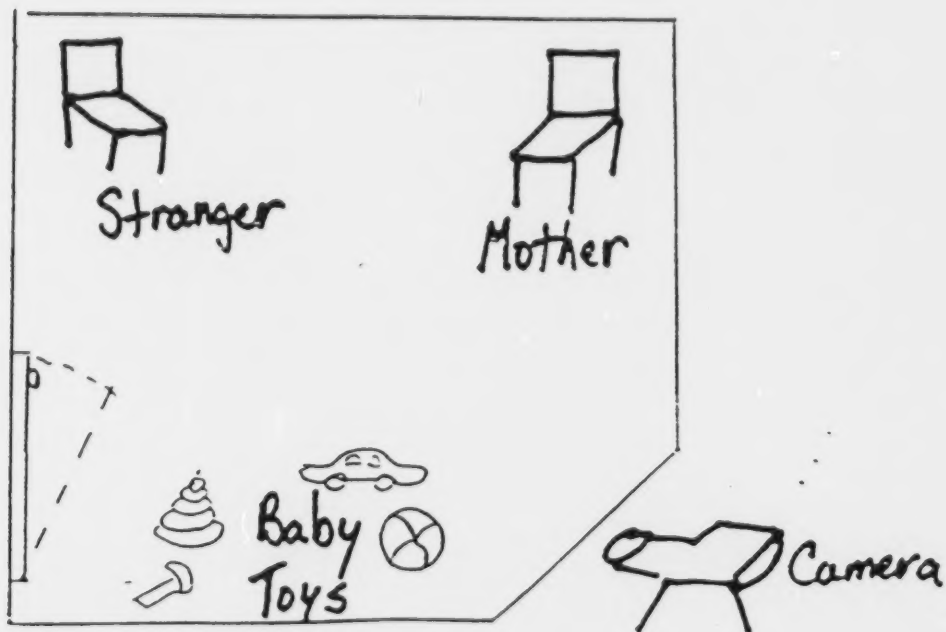


Figure 2
Arrangement Used in Seattle



the Strange Situation are the moments of reunion. It is important to maximize the likelihood that the child's face will be seen and recorded at this time. Two cameras and the use of a split screen may seem like a good idea, but too often there are technical difficulties (while we switch camera's and screens, looking for the child) that result in loss of data at the moment of reunion. Split screens can also be confusing, as when the mother and child, recorded on different screens, appear to be moving away from each other, when in fact they are moving toward each other. In the NICHD Study, only one camera is to be used with camera operators working hard to maximize the likelihood of seeing the child's face at the moment of reunion.

All set-ups have in common a triangular arrangement of the mother, the Stranger and the child's toys. When the child is in the center of this triangle, he/she should be equidistant from the mother and the toys.

A. Toys

The following toys that will be sent by the Washington Site* or ordered by each site using an order form** should be grouped in the child's area and arranged attractively for play:

- pull toy**
- plastic milk bottle and small objects*
- toy telephone**
- peg bench and plastic hammer**
- silver measuring spoons* and nesting cups**
- stacking rings*
- Jumbo Knob Size Board**
- bus plus driver and passengers**

B. Clock

A digital, battery operated "car clock" should be purchased for about \$5.00 and stuck to the door where the stranger can see it and use it to time her episodes.

C. Personnel

The Strange Situation requires the following personnel: Visit Coordinator, Stranger (must be a female who is unfamiliar to the child) and a camera operator. A fourth person should be available to babysit siblings brought to the assessment (which will occur from time to time, although we should provide babysitting money so that they can be left at home). All personnel must be thoroughly familiar with the procedure. The Stranger must be someone whom the child has not seen at any time during the 15-month assessments. The Stranger may have been seen at the 6-month assessment. The roles of the Stranger and the Camera Operator will be discussed in detail in a later section.

D. Instructions to the Visit Coordinator

The Visit Coordinator has the responsibility of supervising the assessment. As such, he/she acts as a director for the camera operator, a prompter for the Stranger, and a coach for the mother. The various tasks of the Visit Coordinator are described below.

1. It is the Visit Coordinator's responsibility that 8 episodes are timed carefully. Making them longer does not make them better. Allow enough time to give the mother instructions. The Stranger will time episodes in which she is present, signaling when Mother should leave and return.

2. It is the Visit Coordinator's responsibility to coach the mother through the episodes of the Strange Situation, described in the next section.

III. A DESCRIPTION OF THE EPISODES

The eight episodes are described below. Instructions to the Stranger, mother, and Camera Person are included. We have annotated the original instructions provided by Ainsworth et al. (The original instructions are single-spaced, and our additions are double-spaced.)

Episode 1: Mother, Child, and Visit Coordinator

This is a very brief, introductory episode. M and Baby are introduced to the experimental room. M is shown where to put the baby down and where she is to sit after having put him down. M has been instructed to carry the baby into the room.

Basically, in this episode, the camera person should start recording before the mother and child enter. The first shot should be a long shot to show coders the room. After the mother sits in her chair, move in on the child. At all times we should see the child's entire body. Do not be so close in on the child that we cannot see the movement of limbs, or keep up with the child when he/she moves about the room.

The Visit Coordinator tells the mother to lead the child into the room. Then the mother sits to see what the child will do. The Visit Coordinator leaves.

Episode 2: Mother and Child

M puts B down midway between S's and M's chairs, facing the toys. She then goes to her chair and reads (or pretends to read) a magazine. It is expected that B will explore the room and manipulate the objects in it, especially the toys. M has been instructed not to initiate an intervention, although if B obviously wants a response from her, she is to respond in whatever way she considers appropriate.

For 2 minutes M will direct B's attention neither to the toys nor to other objects in the room. If, after 2 minutes, B has not begun to explore the toys, a signal is given to M (a knock on the wall) for her to take him to the toys and to try to stimulate this interest in them. One minute is allowed for this stimulated exploration. Meanwhile E times the episode, beginning when M puts B down. He signals M when 2 minutes are up if, in his judgment, B needs stimulation. When 3 minutes are nearly up, he cues S to go to the experimental room.

The focus of the observation is on the amount and nature of B's exploration of the strange situation -- locomotor, manipulatory, and visual -- and on the amount and nature of his orientation to M. (pp. 36-37)

Begin timing Episode 2 for 3 minutes when the visit coordinator leaves. In the NICHD study, we have made slight

variations to Ainsworth's original instructions (above). If after two minutes the child has not begun playing with the toys on his/her own, the mother should be cued to help him/her. In the present study, the Visit Coordinator should open the door and whisper to the mother to try to get the child to play with toys by moving on to the floor with the child.

In the NICHD study there will be no magazines in the room. The mother simply sits in her chair and responds to the child as seems necessary and appropriate.

Episode 3: Stranger, Mother, and Child

S (who has never met B before) enters and says to M: "Hello! I'm the stranger." She immediately seats herself in S's chair and remains silent for 1 minute. She may watch B, but should not stare at him if B seems apprehensive of her. At the end of 1 minute, S begins a conversation with M. M, meanwhile, has been instructed not to begin talking until S initiates interaction with B. At the end of another minute, S initiates interaction with B. At the end of 3 minutes, M leaves the room unobtrusively, leaving her handbag behind on her chair and choosing a moment to leave when B seems occupied either with S or with the toys.

The focus of the observation is on how much and what kind of attention B pays to S, in comparison with the attention he pays to the M or to exploration, and on how B accepts the S's advances (p. 38).

When S enters she says "Hi, I'm _____. I'll visit with you in a minute."

Instead of listening for knocks from the Visit Coordinator that would signal transitions within this episode (as is classically done), Strangers should do their own timing. They should wear a watch with a second hand or better yet, a built-in stop watch. They should also have a clock on the door to look

at. After one minute the Stranger talks to the mother. "In a minute I'll see if CHILD will play with me. Then I will nod for you to leave the room quickly." After another minute, the Stranger gets down on the floor with child. If C is not playing with anything, then the bottle is a good toy to start with. Otherwise, S should play with something that the child has been engaged with and try to develop some nice give and take interaction. Don't entertain; interact. After one minute of play with the child, and when the child is distracted, the Stranger should nod to the mother as a signal for her to leave.

After the instructions, it is best if the Stranger always talks about the same thing. For example: "What a cute child. Has she been walking long? Does she have any of these toys at home? Has she had her nap today?" Of course, this should be a conversation, and some mothers will talk more than others. Be natural. The Stranger's approach to the child should be gentle and non-intrusive. Select your strangers for their warmth, sensitivity, and experience with babies (but remind them that this is a "waiting room"). The Stranger should avoid prolonged eye contact or face-to-face orientation to the child. A side-by-side orientation, with focus on the toys, is tolerated better by children. When possible, the Stranger should follow the child's lead in toy selection and play. The Stranger must be careful not to obstruct the camera's view of the child or get between the mother and the child. Think of the child as monitoring the mother's whereabouts at all times. Don't

interrupt the invisible cord between the child and the mother!

Some very wary babies do not want to play with the Stranger. When this becomes clear, go closer to the child and try to engage her while she holds onto mother. If that doesn't work, the S can tell mother to get on to the floor with child, not to interact but to be a support. When some kind of engagement has occurred, the S can nod to mother to leave. It's not necessary that mother return to her chair and leave. This is also true for mother's departure in Episode 5. The Stranger should play with the child warmly, but not intrusively. Follow the child's lead. If the child is not engaged with a toy, the plastic bottle is a good toy with which to start. Drop one object in, then offer one to the child to drop in. The mother will be instructed to try to leave the room quickly when the Stranger gives her a nod as a signal. Lots of children know the instant their mother leaves. Others sense it after a few seconds. The Stranger should diminish her activity with the child to allow the child to notice Mother is gone.

Episode 4: Stranger and Child

E begins to time the episode as soon as M leaves the room. M, meanwhile, comes to the observation room. As soon as M has gone, S begins to reduce interaction with B, so that B has a chance to notice that M is gone, if, indeed he had not already noticed. If B resumes exploring, S retreats to her chair and sits quietly as M did previously, although she is to respond to any advances B may make. We are primarily interested in the amount of exploring B will undertake in contrast with the amount he did when he was alone with M.

If, however, B cries, S will intervene, trying to distract B with a toy; if this fails to calm him, S will attempt to comfort B by picking him up if he permits and/or by talking to him. If S is successful in comforting B, she then puts him down and again attempts to engage his interest in the toys.

Three minutes are allowed for this episode, although it may be curtailed should B become highly distressed and unresponsive to S's efforts to distract or comfort him. Just before 3 minutes are up (or sooner if the episode is to be curtailed), E cues M to return to the experimental room.

We are interested in the amount and nature of B's exploration in contrast with earlier episodes. We are also interested in B's response to M's departure--crying, search behavior, and any acute distress. B's response to the stranger is also of importance, including his response to being picked up and put down, and any clinging that he does (p. 38).

Once she has left the room, the mother should be told that she will be out of the room for 3 minutes unless the child cries or unless the mother thinks it is necessary for her to return sooner. We need to remind the mother that she may return to her baby at ANY time, though we prefer that she wait until we signal her to return. After the mother leaves, the Stranger gradually decreases her involvement with the child, and returns to her chair if the child plays well alone. A common mistake is to not reduce interaction soon enough. We want the child to realize the mother is gone and to experience some distress. If the child is really upset, the Stranger should not hesitate to pick him/her up and try to comfort him/her. Then, when the child is ready, the Stranger tries to engage the child in toys again.

A classic rule of thumb is that an episode is curtailed

after one minute of continuous crying or 30 seconds of hard crying. Do not leave the decision to return up to the mother--unless of course she is forthright about it. The Visit Coordinator should control if and when an episode is curtailed.

It is very hard to have an iron clad rule about how soon to send the mother in for a distressed baby. Babies who are crying hard can wait 30 seconds. The intermittent criers can go all three minutes. This is extra hard because we are eliminating the knock to let the Stranger know mom is coming. The Stranger should be keeping track and know when mother is about to return. The Experimenter should keep an eye on the Stranger. Often the Stranger has the best idea about when to send mother back. If she looks right into the camera and nods, send Mother in immediately. The Stranger's behavior in this episode is very important. The Stranger should first try distracting CHILD with toys. Remember, the Stranger is to behave as if she is a nice lady in a waiting room, comforting a child until the mother returns momentarily. If the child does settle, the Stranger should try to get him/her to return to play, and the Stranger should return to her chair. It frequently happens, however, that the child settles only in the Stranger's lap, and cannot be put down. In that case, the Stranger should sit on the floor in such a way that the child can simply toddle off the Stranger's lap and go to the mother when she returns. Put tape on the floor so S sits at least 5 feet from the door.

If the child is distressed the Stranger's behavior will vary

according to HOW distressed. It is not necessary to leap in immediately to comfort. We want to see if a baby will self-comfort or redirect to toys. It's OK if a mild or moderately distressed baby is by the door at first. It's more disruptive to fetch the child from the door repeatedly. The Stranger can wait a bit to see if they move away to toys on their own. However, a severely distressed child should simply be picked up and moved from the door. Stranger should sit on the floor with child on her thigh (cross legged is too low and children have a harder time getting up). If time and the child permit, gently move the child on to the floor. The child should be oriented to the door. S can signal for mother to return quickly.

If the Stranger has been trying to comfort the child when the mother returns, the Stranger should restrain the child until mother is inside the door, then relax her arms. Do not, however, push the child away or to the mother. The Stranger should be conscious of the invisible cord between the mother and child. If a pile of toys lies between the child and the door, the Stranger should find a way to clear a path before picking up child, so that child can approach the door, if she desires, once the mother returns. At the end of Episodes 4 and 8 the Stranger NEVER should be playing or interacting with the child, so that child is distracted when the mother returns.

Sometimes children do not settle, no matter how skilled the Stranger. Strangers must be calm in the presence of a very distressed child. The Stranger will then send a significant

glance toward the observation window that means "Send in mother!"

The mother will be with the Visit Coordinator in the observation room. The Visit Coordinator must cue the mother to return (which will start Episode 5) about 30 seconds before Episode 4 is up. It will take her about that long to listen to your instructions: "When its time for you to go back I'll knock and open the door. You go right in. Pause to see what CHILD does, then do what seems natural. Get your child to return to play and go to your chair. We'll knock for you to leave again. When you leave, walk to the door, put your hand on the door knob, say bye bye and walk out."

Episode 5: Mother and Child

M approaches the closed door and speaks outside, loudly enough that B can hear her voice. She pauses a moment, opens the door, and pauses again, to allow B to mobilize a response to her if he is going to. M is instructed to make the baby comfortable, finally settling him on the floor, and interesting him in the toys. Meanwhile S leaves unobtrusively. After 3 minutes, or when it is judged that B is settled enough to be ready for the next episode, M is signaled to leave. She picks a moment (if possible) when B seems cheerfully occupied with the toys, gets up, puts her handbag on the chair, and goes to the door. At the door she pauses and says "bye-bye" to B and leaves the room, closing the door securely behind her.

In general in this episode we are interested in observing B's response to M after her absence and their interaction after her return (p.38-39).

How the Stranger leaves the playroom early in Episode 5 is very important. She must be unobtrusive and NEVER interfere with the reunion. She must wait until the initial reunion is

definitely over. No harm is done if she waits a little too long to leave, but interrupting the reunion can be a critical error. The Stranger should look at her hands, folded in her lap. She should not talk to the mother or child. She must not say "See Mama!" or "Bye bye!" She shouldn't move between the mother and child, or be in the way of the camera's view.

The mother should leave behind her handbag, the diaper bag, or similar reminder of her. It is not necessary for her to put it on the chair or do any thing particular with it, she simply carries it into the room and it stays there throughout the assessment. The knock that is the signal for mother is a single loud knock that can be heard by her and on the tape.

Episode 5 can be a little longer than 3 minutes if it takes the child longer to settle. The mother should not be cued to leave before the child is settled. It rarely happens (about 3-5%) that at this point, the Visit Coordinator wonders if the procedure should be aborted, because the child is so utterly distressed. The Visit Coordinator will soon recognize those few infants who have an especially frantic, desperate, or helpless quality to their distress. Give the mother an extra minute to settle the child before cueing her to leave. The mother can still be cued to leave if the child has settled, but not returned to independent exploration. (If the episode is prolonged too long, the mother will know something is odd, since we told her the episodes would be about 3 minutes long.) If the mother is reluctant to leave because it is obvious to her that the child

won't stand for it, ask the mother to leave quickly and reassure her that the Stranger will return to the child immediately. Tell the mother this by opening the door and talking to her directly. Have the Stranger waiting by the door to enter as the mother leaves. Basically, the mother and the Stranger will exchange places and the mother will return quickly after that. Do not leave acutely distressed babies alone, even for 10 seconds. A standardized, uniform length of separation is not critical for coding, and for numerous good reasons, we do not want to severely stress infants.

Many of the babies on the pilot tapes were quite distressed, making it hard for mothers to leave for the second time. It's really important that a second separation occur, even if we don't have the child alone at all. A rule of thumb would be: If the baby is still crying after 3 minutes and 30 seconds, don't knock for the mother to leave. Send the Stranger in, who will tell the mother to say bye and leave quickly. The Stranger may have to be gently firm, taking the child from the mother and telling her she should leave for just a few seconds.

Episode 6: Child alone

E begins timing when M leaves. Three minutes are allowed for B to explore the room while he is alone. If he cries when M departs, he is given a chance to recover in the hope that he may do some exploring, but if he becomes acutely distressed the episode is curtailed.

We are interested, of course, both in B's exploratory play (if any) when he is left alone in an unfamiliar situation and in his reaction to his mother's

departure--crying, search behavior, grumbling vocalizations, tension movements, and so on.

Episode 7: Stranger and Child

Just before the end of the 3 minutes (or upon a decision to curtail Episode 6), E cues S to return. S approaches the closed door and speaks outside, loudly enough that B can hear her voice. She pauses a moment, opens the door, and pauses again to allow B to mobilize a response if he is going to do so. E begins timing Episode 7 as soon as S enters.

If B is crying, S will first attempt to soothe him, picking him up if he will permit it. When and if he calms, she will put him down and attempt to engage him in play. If he gets interested in the toys and begins to play, S will gradually retreat to her chair. If B is not distressed at the time S enters, she invites him to come to her. If B does not come, she approaches B and attempts to initiate play. If he becomes interested in the toys and begins to play with them himself, S will gradually retreat to her chair. In either case, if B signals that he wants interaction or contact with S, she will respond to his wishes, and in general she is to gear her behavior to B's behavior.

In this episode we are interested primarily in B's response to S--how readily he is soothed by her, whether he seeks or accepts contact, whether he will interact with her in play--and in how this response compares with B's response to M in the reunion episodes. Also we are interested to see whether the pull of the toys is strong enough that B permits S to become nonparticipant (p. 39).

The same recommendations for the Stranger's behavior before and during the first reunion apply here as well. In general, this separation affects the child more than the first, and distress is quite common.

After the Visit Coordinator cues the Stranger to return, the Stranger opens the door and pauses inside. If the child is crying at the door, the Stranger should pick him/her up and try

to calm him/her. As the child calms down, the Stranger introduces some toys while the child is on her lap, eventually aiming to put the child down to play with the toys while the Stranger returns to her chair. This will be harder to do than it was in Episode 4, and many children will have none of it. In that case, the Stranger may sit on the floor, the child on her thigh. The stranger times the episode and decides when the mother should return, nodding to E. The Stranger then follows the reunion instructions above.

Some children are not upset. In that case, when the Stranger enters, she greets the child and chats briefly before returning to her seat. The Stranger should be responsive if the child initiates some interaction, but if the child is playing happily, the Stranger just sits in her chair.

The mother and the Visit Coordinator will again be in the observation room.

Episode 8: Mother and Child

Just before the end of 3 minutes (or upon a decision to curtail Episode 7), E cues M to return. M opens the door and pauses a moment before greeting B, giving him an opportunity to respond spontaneously. She then talks to the baby and finally picks him up. Meanwhile S leaves (p. 39-40).

It is important that the mother's pause is just that. A couple of seconds is all that is needed. Instructions to pause for 10 seconds are excessive. Twenty seconds before sending the mother in from the observation room, remind her about what she

should do. Don't say to pause for a specific length of time, just say, "Pause for a good deep breath after you enter, then greet CHILD as you normally would. Wait a bit and see what he/she does, then, even if she does not seem to need it, pick him/her up. Do what you normally would under the circumstances, eventually returning CHILD to play and yourself to your chair. After 3 minutes, we will be done with this part of the visit and we will have a snack."

We want to avoid the situation of the child standing, waiting at the door when the mother is sent back. About 20 seconds before reunion, the Stranger should gently lift the child and bring him/her to the toys. If the child's path is strewn with toys, the Stranger should try to clear it before the mother enters. It is harder to code when the child trips over toys on the way to the mother. The S sits on the floor, holding child on her thigh, gently preventing child from returning to the door. If the Stranger is uncertain what to do, when, for example, the mother returns unexpectedly and is holding the child in her arms while looking at a picture on the wall, the Stranger should make no sudden movements that might frighten the child. I have seen Strangers practically drop the child in their haste not to interfere with the reunion. It is better to simply pause, oriented to the door. The Stranger should be still, giving the child a chance to orient and make a response to the mother. We can observe and code the child's behavior even if he/she is in the Stranger's arms, IF the Stranger does nothing to confuse the

child. After a long pause the Stranger can bend to her knees and gently release the child onto the floor, if mother has not already taken child from Stranger's arms.

Finally, the Stranger must keep in mind where the camera is. She should be aware that, at the moment of reunion, we get the best data if we have a view of the child's face. The Stranger must not get her body between the child and the camera. The Stranger may try to gently position the child so that we can get a good view of him/her when the mother returns. It is not always possible to do this. For instance, if the child is happily playing with his/her back to the camera and the Stranger has been sitting quietly in her chair for three minutes, it would be odd to swoop down and turn the child to face the camera just before the mother enters. In that type of situation, no response is best.

The role of stranger is a difficult one. On the one hand, she is expected to refrain from undue intervention in order to permit the baby to play, search for his mother, or even display distress spontaneously. On the other hand, she is instructed in Episode 3 to approach the baby and to attract his attention away from the mother and to the toys, and in the separation episodes to distract or comfort the baby if he is distressed. All strangers to some extent geared their behavior to that of the baby, but they had individual styles in approaching the baby, in interacting with him in play, and in attempting to comfort him if he was distressed. A baby's cries were distressing to all strangers, and consequently it was especially difficult to control, through instruction, just how they should behave in separation episodes (p. 40).

Remember that the 30 second cry rule applies any time the child starts crying. If distress escalates at any point to continuous crying, the episode will be cut short.

We will develop training tapes for Strangers. Complete training for Strangers includes viewing these tapes with accompanying commentary and discussion, and at least three practice assessments with feedback. The Lab Visit Coordinators at each site must "certify" strangers and camera operators. the Evaluation Checklist can be used to both train and critique. Susan Spieker will "certify" Lab Visit Coordinators based on a minimum of two Strange Situations each.

When Episode 8 is over the Visit Coordinator enters the room and tells the mother that "Comings and Goings" is over.

IV. INSTRUCTIONS TO THE CAMERA OPERATOR

The camera operator has a crucial role in the Strange Situation procedure. If the camera is not focussed on the critical behaviors as they happen, the assessment may not be codable. It is not wise or possible to code a poorly run or poorly filmed Strange Situation.

The camera operator should be thoroughly familiar with the general purpose of the Strange Situation. Below are the principles that should be emphasized:

1. The focus is on the child's behavior. We do not need pans to the Stranger or mother from time to time, because crucial child behavior will be lost. If the mother and child or stranger and child are in close proximity or contact, however, then it is appropriate to frame the shot so that the whole child as well as mother's face and upper body, perhaps, are included.

2. At the same time, however, a coder needs certain contextual cues. It is a good idea to start Episode 1 with a wide shot so that the coder gets a look at the room and the way it is laid out, particularly where the door is and the mother and Stranger's chairs. The audio system should be sensitive enough to pick up the Visit Coordinator's knocks, since these are important indicators of what is about to happen. Similarly, coders need to know the moment the door opens when the Stranger or the mother are returning to the room. If the door is not on camera, be sure that the sound of the opening and shutting door is clearly audible. If there is a problem, a particular site needs to develop other ways to make these moments clear to the viewer of the tape. We suggest quickly passing your hand in front of the lens at the moment the mother opens the door.

3. Be prepared for those times when children are likely to move fast, as at the moment of reunion. It might be wise to experiment with a slightly wider shot at these times, with the expectation that you will zoom in again on the child when his/her location is stable. Anticipate the need to move the camera up when the mother picks the child up at reunion. Don't focus the camera or make adjustments at the moment of reunion. In Seattle we frequently had the problem that, when the camera zoomed in on the child from a rather wide shot, it needed to be focussed again. We have lots of fuzzy close-ups of the child's face during those seconds right after reunion when the camera operator is focussing, and it was quite frustrating to watch. If this is

a problem with your camera, it would be best to avoid such dramatic changes. It is best to remain focussed on the child at all times, to the extent that we rarely see all of the mother or the Stranger. This makes for a very codable assessment.

4. Turn on the camera's time/date function at the beginning of Episode 1 and let it run until the snack is over. It starts at zero. It must have seconds, but nothing faster than seconds. We don't need or want any other info (site, date, etc).

5. Precede the Strange Situation by taping a board listing date, subject number, Lab visit coordinator ID, and site.

6. Mail the original Solitary Play and Strange Situation to Susan Spieker, after removing plastic tab from tape. Make sure tape is labeled as above, and protected.

NICHD Study of Early Child Care

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August 5, 1992

To: PIs, Project Coordinators, Visit Coordinators, and Strangers

From: Susan Spieker, Joyce Moon

Re: Strange Situation stranger training tapes and manual addendum

In July the Steering Committee requested that we develop a "snippet" tape to be used by sites in training strangers for the Strange Situation 15 month lab procedure. In response we have put together two training tapes and an addendum to the Manual that explains each excerpt on the tapes. There are many ways that these materials could be used. We recommend that they will be viewed and discussed in groups including the VCs, Strangers, and Camera Operators from each site.

We have tried to show the various kinds of challenging situations that are encountered in the course of running Strange Situations, and present our recommendations on the best way to manage them. More importantly, we have tried to emphasize the principles that VCs and Strangers should use when making a judgment call, since we can't possibly anticipate every situation that might occur.

The first training tape contains two complete Strange Situations, including the VC instructions to the mother taken from Solitary Play. The first segment shows a child with minimal distress, the second a child with high (but not exceptional) distress.

The second training tape contains 51 snippets illustrating problems and proper procedures for different child responses in the various Strange Situation episodes.

Our comments here are meant to clarify the original manual and provide specific advice for typical problems we've identified since data collection began. Please review these materials carefully and discuss them with your staff. Please continue to use the manual, this addendum and the feedback letters you have already received in order to train your staff and maintain a high level of performance. We hope that all of these materials will make it easier for you to carry-out effective self-evaluations. If you continue to have questions, contact one of us.

The National Institute of Child Health and Human Development

University of Arkansas, University of California, Irvine, University of Kansas, University of Pittsburgh, Temple University, University of Virginia,
University of Washington, Wellesley College, Western Carolina Center, University of Wisconsin

NICHD STUDY OF EARLY CHILDCARE

ADDENDUM TO CHAPTER 17.3 STRANGE SITUATION MANUAL 8/5/92

This training tape has been compiled to show strangers a broader range of experiences with children than they might otherwise see. We gratefully acknowledge the hard work that all of our strangers do, and want to point out that these examples have been taken from tapes where the strangers were often relatively inexperienced.

As you view these edited clips, you will notice some unusual room arrangements, camera work mistakes, reflection problems, and clarity difficulties, as well as stranger errors. Most of these problems have been corrected. I will occasionally call to your attention some of these problems in the narrative. The picture quality for some especially dark or light sites can be somewhat improved by adjusting the color and brightness controls of your monitor.

In designing our strange situation procedures, we made several decisions which may make our stranger behaviors somewhat different than are traditionally seen..

1. Our strangers play an active role in the timing of the episodes. They time their own episode 3 behaviors (1 minute of silence, 1 minute of conversation with the mom, and 1 minute of play with the child), and nod to the mom when it is

time for her to leave. Additionally, the stranger is responsible for gauging the child's level of distress and nodding to the visit coordinator if she feels that the episode (4 or 7) should be curtailed.

2. Strangers are responsible for having children at least 5 feet away from the door for reunions. We realize that this is difficult to accomplish in some cases, but this is a fairly hard and fast rule. Some rooms are quite small, some doors open in, or the view at the door is otherwise obstructed.
3. To facilitate the stranger's interactions with the child, we have generally placed the stranger's chair further into the room rather than next to the door as it is traditionally placed. This requires the stranger to be sensitive to the "attachment tether" of the mother and child, and also requires that she move quickly between the child and camera when entering and leaving. Strangers should try to be in their chairs for separations and reunions, but this is frequently impossible.
4. Children's faces (at least in profile) need to be visible at reunions. Strangers need to position children, as gently and unobtrusively as possible to ensure this.
5. Because we want to be able to see children's expressions as clearly as possible, the camera will remain zoomed on the

child (with the child taking up the entire screen).
Therefore, the knock on the door is assumed (by the coders) to be the mom's entrance and the stranger must freeze in position at the knock. Strangers should not move themselves or children after the knock.

VIDEOTAPE NARRATIVE - Tape 1 of 2 (20 secs blank)

EXAMPLE OF AN UNDISTRESSED CHILD'S STRANGE SITUATION

Mom: Sarah (long brown hair, white T-shirt, blue jeans)

Child: Danielle (brown hair, white blouse, pink print sunsuit)

Instructions for the Strange Situation during the Solitary Play procedure: (05:00-09:20) The visit coordinator emphasizes getting the child back to play slightly more than we like now. She also emphasizes responding to the child's cues and behaving naturally. At the end of her instructions, she gives the mom an opportunity to ask any questions, and she responds to the mom's questions.

The Strange Situation:

(00:00) Episode 1 The visit coordinator brings the pair into the room, gives the mom very brief instructions, and reminds the mom to follow the child's lead. (As we know now, the mom should not have brought her purse and jacket into the room and should have walked the child into the room.)

(00:26) Episode 2 The VC leaves. Mom seems comfortable interacting with her child.

(03:29) Episode 3a The stranger enters, briefly introduces herself, and goes to her chair. The child does some looking and smiling at the stranger, but the stranger is minimally responsive at this time.

(04:31) Episode 3b The mom expresses some uncertainty about her behavior and the stranger reassures her by saying that she is doing fine and that she should take her cues from her child. Then the stranger goes through the instructions, mentioning to the mom not to block the camera's view of the child when she returns.

(05:31) Episode 3c The stranger starts her interaction with the child by gently talking to her about what she is already playing with. Then the stranger attempts to engage the child with the puzzle, which the child has already tried playing with. The stranger offers the child pieces and the child responds by accepting them. The stranger also allows the child time to respond, pacing her interactions to the child's speed.

(06:32) The stranger nods for the mom to leave and stops interacting with the child until the mom is out of the room.

This is to ensure that the child has the opportunity to notice that mom has left.

(06:39) Episode 4 Since the child is very contentedly playing with the toys and has not moved since the beginning of the procedure, the stranger clears a path to the door and returns to her chair. The stranger does not initiate any further interactions with the child. At 09:29 (since reunion should be happening in 10 seconds) the stranger gently slides the child into a position where the camera will be able to see her face for reunion. It probably would have been better if the stranger had moved her 5-10 seconds sooner.

(09:39) Episode 5 The stranger leaves after 20 seconds, which is fine. She chose to leave at that point because the mom had attempted to initiate a conversation with her. The stranger chose to walk quickly between the camera and child rather than between the child and mom (thus, not breaking the attachment tether).

(12:37) Mom gets up to leave at the knock and says bye-bye when her hand is on the doorknob. The mom does not wait for a response from the child.

(12:45) Episode 6 The child plays alone comfortably.

(15:46) Episode 7 The stranger greets the child and moves toys to the center of the floor. Then she goes to her chair and does not initiate further interactions since the child is not distressed. About 45 seconds before it is time for the reunion, the stranger clears the path to the door, moves the child further into the room, and turns her so that she is facing the camera. The stranger gently talks to the child during this maneuvering.

(18:49) Episode 8 The mom pauses at the door, long enough to give the child time to respond, then picks her up as instructed. The stranger waits until the mom has gone to her chair and the child is playing (approximately 30 seconds) before leaving quickly.

(22:00) The visit coordinator returns and ends the procedure. This is just 10 seconds longer than the end of the three minute episode 8. It is always better to run just a few seconds (not minutes) over rather than accidentally cutting the episode short.

EXAMPLE OF A DISTRESSED CHILD'S STRANGE SITUATION

Mom: Mary (chin length brown hair, white blouse, print pants)

Child: Peter (white with blue poka-dots romper)

Instructions for the Strange Situation during the Solitary Play procedure: (05:00-10:17 [then clock resets to 00:00]) The visit coordinator does a good job of responding to the mom's questions and concerns and emphasizes that the mom should do whatever is natural for her. The VC also emphasizes that mom should leave quickly after she says bye. This is a mom who has lots of questions and the VC does a good job of handling them.

The Strange Situation:

(00:00) Episode 1 The VC orients the mom to the new room and answers her questions. Again, we prefer that the mom walk the child into the room.

(00:44) Episode 2 Mom seems comfortable interacting with her child.

(03:46) Episode 3a When the stranger enters and greets the mom, the mom starts talking to her. The stranger says again that she will visit with her in one minute. The child smiles at the stranger, and she is minimally responsive in this episode.

(04:47) Episode 3b The stranger briefly reviews the procedures and reminds the mom of where the filming is done.

(05:29) The mom asks "And when I come back in I don't pick him up or anything, I just sit down?" The stranger replies "You can

do whatever is comfortable and feels natural for you. So whatever you think he needs is fine."

(05:48) Episode 3c The stranger attempts to interact with the child with the toy he is playing with.

(06:48) The stranger nods for mom to leave on time, unfortunately, the child is approaching the mom, so this is a poor time to nod. It would be better for the stranger to wait a few seconds. Since the child is following the mom to the door, the stranger followed the child, and was ready to restrain him if he had gotten to the open doorway.

(06:58) Episode 4 The child is slightly fussy at the door, so the stranger attempts to reengage him with toys, without moving him away from the door. She allows him to remain at the door, without forcing the interaction until him becomes more distressed. (It is fine for a low-to-moderately distressed child to stand at the door until 1 minute before the reunion.) The stranger tried to briefly comfort him at the door, and moved the toy, that he had dropped, away from the door. Then the stranger picked up the increasingly distressed child, tried to comfort him, and moved him away from the door. The stranger was able to distract him briefly, but when he became upset again, she decided to end the separation, nodded for mom to return, and positioned him for the reunion.

(08:57) Episode 5 The stranger was able to position herself behind the child and remained motionless for about 15 seconds. Since this was a distressed child, and because the mother and child were seated together, the stranger left after 15 seconds, rather than waiting longer. (The camera zooms too much and cuts off the bottom half of the child.)

(11:56) The VC knocks for mom to leave. Mom does say bye at the door, but she takes a little longer than desired with "I'll be back in a minute," which would give a very active child enough time to get to the door.

(12:06) Episode 6 He starts with a very high level of distress - holding his breath for about 5 seconds, but then calms down to a moderate level of distress. This was ended in 35 seconds, but could have possibly gone longer since he might have been starting to self settle. It doesn't matter however, he was distressed and the separation had gone on long enough.

(12:41) Episode 7 The stranger tried to comfort him by talking to him, holding him, and trying to distract him. When this didn't work in 20 seconds, the stranger nodded for mom to be returned and tried to position the child for reunion. The stranger nodded again when the mom hadn't returned in 5 seconds. (The mom had asked the VC a question and the VC was answering it.) The stranger nodded again in 15 seconds. Even though the mom did not return when the stranger expected her,

she held onto the child and kept him away from the door. She also held him in a sitting position so that he would be less likely to catapult himself to the door, possibly falling on his way there.

(13:30) Episode 8 The stranger remained motionless on the floor for 15 seconds, until the mom had sat in her chair with the child. She then left quickly.

(16:40) End - 10 seconds after the end of 3 minutes.

VIDEOTAPE NARRATIVE - Tape 2 of 2 (20 secs blank)

(Pause at the black section before each clip)

Preseparation Behaviors

01. (03:15, Boy, brown hair, blue sweatshirt) At the stranger's entrance (03:37), she correctly instructs the mom to return to her chair.
02. (02:45, Girl, brown hair, white shirt) Stranger doesn't instruct the mom to return to her chair.
03. (04:00, same child) Stranger doesn't instruct mom to return to her chair until the end of her instructions, and then does it in a fairly unassertive manner, so that mom remains on the floor until it is time for her to leave.
04. (04:27, blond boy, purple and blue shirt, black shorts) The stranger gives complete instructions to mom, mentioning that mom should respond to him naturally, and reminding her not to

block the view of the child. (The camera cuts off the top of the child's head several times.

05. (5:24, same child) The stranger attempts to engage the child with a toy that he is playing with and is not intrusive in attempting to engage him. When he points to a new toy, the stranger responds.
06. (12:17:34 girl, light brown hair, pink overalls) This is a child who has already made several trips to mom in preseparation, and the stranger positions herself between the child and her mom, forcing the child to go around the toys to get to her mom. It would have been better for the stranger to have positioned herself against the white wall on the other side of the child.

The Wary Child

07. (06:51, boy, dark blond hair, gray overalls) This is a wary child that the stranger attempts to engage for too long. He becomes totally stressed and very clingy with mom.
08. (10:58, same child) Episode 3 ends up being about 10 minutes long in this procedure. This child is so stressed that the stranger actually has to take the child from the mom, like they were doing an abbreviated 6/7 separation. The stranger could have briefly held the child ventrally, with him facing her.

Proper wary child procedure:

1. Try to engage the child for 1 minute. Do not go beyond that time. If the child has retreated to the mom, return to your

- chair. (If the child just ignores you and plays alone, knock for mom to leave as you normally would.)
2. Instruct the mom to move to the floor and to get the child back to play.
 3. As soon as the child is playing (or has moved away from the mom) the mom should leave. The mom does not need to return to her chair before leaving.
 4. The stranger should be supportive of the mom's efforts, guiding her behavior, but be in her chair and in the background as much as possible.
 5. If the child won't engage with the toys (or move away from the mom) after two minutes, the stranger should tell the mom that she will hold the child so that the mom can leave (like you would for an abbreviated 6/7 separation).
09. (05:24:0, boy, dark hair, light shirt) The stranger tries to engage him for too long and doesn't retreat to her chair. The stranger also failed to take the child from the mom which would have enabled her to leave. (Also note, this is a case where the mom had a pacifier for the child in her pocket. Whenever possible, the VC should try to keep pacifiers out of the lab rooms.)
10. (10:04:05, blond boy, white print romper) Again, the stranger attempts to engage him for too long.
11. (05:19, girl, light brown hair, blue print sundress) The stranger follows the wary child procedure, retreating to her chair at the end of 1 minute, and verbally instructing the mom to leave when the child moved away.

Disengagement Behaviors

We want children to experience gradually increasing stress, and to do this, the children need to be aware that their mom has left the room. So, strangers should briefly disengage after their nod for mom to leave and then retreat to their chair fairly soon, if possible.

12. (05:55, girl, brown hair, white shirt and white print overalls) The stranger does a nice job of allowing the child to realize that her mom has left. The stranger does stay on the floor a little longer than necessary, but has reduced her interactions with the child. (The camera could have been zoomed closer on the child so that she filled the whole screen.)
13. (06:21, blond girl, white blouse and blue jeans) This is a wary child who is prevented (by the stranger) from realizing that her mom has left the room for more than a minute.

Separation Behaviors

Undistressed Children

As I previously mentioned, we want children to have increasing stress throughout the procedure. If the stranger is too friendly and interactive with undistressed children, they do not experience much stress. If a child is not distressed, the stranger should be minimally responsive, regardless of how engaging the child might be, and should not initiate interactions during the separation episodes.

14. (06:19, girl, light brown hair, white shirt, print pants) The stranger is too interactive with an undistressed child.
(There are strong reflections on the glass. Also, mom's purse should not be present.)
15. (4:00:10, boy, black hair, white shirt, dark pants) The stranger appropriately does not engage the child in interactions. She could have greeted him. (Some reflections on the glass.)

Distressed Children

The general rules for distressed children are:

1. Be respectful of the mom's distress and comfort level.
2. 1 minute of steady crying with the stranger present.
This refers to low-moderate level, continuous crying.
2. 30 seconds of steady crying when the child is alone.
Again, this refers to low-moderate level, continuous crying.
4. If a child appears to be hysterical (e.g., high intensity screaming, holding breath, arching, etc.), these times should be shortened to 30 seconds or less with the stranger present, and 15 seconds or less when the child is alone.
5. Even if the mom seems comfortable with high levels of distress for the child, do not extend the separations to the full three minutes if the child is crying hard.
6. If the child is attempting to self comfort himself (trying to focus on toys) or is intermittently crying,

the separations may be able to go 3 minutes, if the mother is comfortable. If the pauses between crying spells are less than 5-10 seconds, one minute is probably as long as you would want the separation to go.

How should strangers comfort distressed children? They should always do the least that they can get away with. We would like separations to go three minutes when possible, but strangers should not attempt to totally comfort a child. We aren't interested in what great skills the stranger has.

If a child is not crying (perhaps) just looks sad, the stranger can allow the child to be at the door or wherever he wants for about two minutes. If the child is at the door, 1 minute before the reunion the stranger should offer toys and try to coax him away. If the child will not engage, the stranger will need to pick him up and position him for the reunion.

At moderate distress levels, the stranger should always offer toys and try to distract the child before picking him up. If this increases the child's distress, try holding and comforting the child.

Strangers can hold children facing themselves (ventrally), and can walk around the room with the child, but they should try to get the child facing away from themselves well before the reunion. Since strangers give the nod for moms to return, it should be rare that strangers are caught standing and holding a child. Strangers should be aware of the door (and camera) when attempting to comfort

children, and not position themselves between the door (or camera) and the child.

I find that the best position for holding children for reunions is for me to be on the floor, with both of my feet to one side (away from the door), which puts one thigh into a level position (sort of on one hip). I place the child on the level thigh facing the door (or in a profile position to the camera). I prefer this to sitting cross-legged because it is difficult for children to get up out of a lap that is in a cross-legged position. If you sit on your heels, your thighs are at a sharp angle which means that the child often cannot get comfortable and you have to hold onto him. Also, if you use my position, you can unobtrusively lean back away from the child, or give him more support and comfort.

If a child is highly distressed, the stranger should usually pick up the child first and then offer toys. If the child is not at all interested in the toy, and it doesn't help to comfort the child, do not persist with it.

If the child is hysterical, arching and screaming, and strongly resisting contact with the stranger, pick her up, move to your position, at least 5 feet from the door, and briefly attempt to comfort. Try to position the child in such a way that she won't hurt herself - either on your lap sitting, sitting on the floor, or even laying on the floor if that is what she wants. It is probably useless to offer toys to this child, and most interactions will seem intrusive, so just restrain the child and expect that mom will be sent in immediately.

Probably my least favorite way for strangers to move or position children is by holding onto them under the armpits. Children are not objects to be dragged around. Strangers need to try to be sensitive and responsive to children whenever possible.

16. (10:06:55, boy, black curly hair, gold shirt, dark overalls)
The stranger does not try to comfort the child or distract him for 45 seconds of continuous crying. After almost a minute and a half she nods for mom to return. The stranger should have moved him away from the door before nodding for the mom to return, and should not have moved back after mom entered.
(Strong reflections on the glass.)
17. (10:52:15, blond boy, blue or green turtleneck shirt, dark print pants) Stranger just tries to distract the child, doesn't offer any comfort. Also, the separation is too long for this level of distress.
18. (10:58:38, same child) The stranger does a good job of trying to comfort the child. I generally find that face wiping is intrusive, so would not recommend this as a method of comforting children. Also, the stranger initially positions herself between the child and the door, so she has to move before the reunion. By reunion they are positioned properly.
19. (13:09, girl, brown hair, pink sundress) This is a highly distressed child who immediately rejects the stranger when she picks her up. at 13:25 the stranger has the child in a fine position (standing between the stranger's legs) and the child is ready for mom to come back. Instead of just moving herself

slightly (so that she wouldn't be between the child and the door), the stranger picks up the child, increasing her distress and resistance. In this situation, the less you do with the child the better off you'll be.

Positioning Children

20. (09:08, boy, red hair, light blue t-shirt, gray pants) This child is positioned perfectly for the reunion, he hasn't moved for the whole separation, and the stranger makes a good decision to leave him alone.
21. (08:55, boy, light brown hair, blue shorts-overalls, no shirt) This child could have easily been turned around for the reunion by just sliding him on the floor.
22. (06:44, boy, dark blond hair, red overalls, white shirt) This child was in a perfect position for the reunion and the stranger moved him so that his back was to the camera.
23. ((1:29:55, blond boy, blue coverall) Child is playing nicely, the stranger unnecessarily stands him up for reunion, but then doesn't hold on to him long enough (she lets go right at the knock). (Dark room.)
24. (11:22:59, blond girl, pink blouse, white print pants) Clip begins with child alone and then stranger's entrance. The stranger has positioned herself between the child and the door so she has to move for the reunion. She also moves the child unnecessarily for reunion and doesn't offer any comfort to the child.

Keeping Children Away From The Door For Reunions

25. (16:15, boy, light brown hair, dark blue shirt, purple pants)
This is a child who has been very active throughout the procedure. The stranger has him positioned well for reunion, and when he starts to stand up early, she moves to a position where she can keep him from going to the door, if necessary.
26. (1:35:50, blond boy, dark print shirt, light shorts) The child is playing nicely. The stranger, instead of just turning him slightly by sliding him on the floor, sits him on her lap, facing the door. Then, she fails to hold onto him, so he is at the door for reunion. (Dark Room.)
27. (18:00, girl, light brown hair, white print shirt and pants)
The stranger should be expecting the reunion to happen in 10 seconds (they delayed sending mom back). The stranger tries to coax her away from the door rather than just moving her. The stranger also didn't clear the toys away from the door. Once the stranger has the child away from the door, she didn't keep her away, so she was quite close when the door opened.
28. (9:51:21, blond boy, blue t-shirt, light blue shorts-overalls)
The clip begins with the child alone, and then the stranger enters. This child was obviously highly distressed and the stranger should have immediately moved him away from the door rather than trying to coax him away. Although this episode was quite short (8 seconds), the stranger shouldn't have roughly dragged the child away from the door after the knock.
29. (17:45, boy, black hair, white tank top, blue shorts) The stranger fails to keep him away from the door so the

separation goes on longer than it should and he is at the door for the reunion.

Although we would rather not have children at the door for reunions, we also do not want children roughly moved away right at reunion. So, if you have failed to have the child away from the door at the knock, you need to freeze in place and do not move to the child. The procedure may need to be rerun if coders are unable to see children for the initial reunion, so be sure to include a separate note with the tape if this occurs.

Reunion Problems

30. (16:20, girl, black hair, white blouse and print pants) The stranger moves her nicely away from the door, but then fails to hold onto her so she goes to the door and the reunion happens behind the door.
31. (12:19:15, blond girl, pink overalls, white blouse) The stranger does a very good job of holding onto the child even though mom doesn't come back for 14 seconds after the stranger's nod for her to return.
32. (9:28:35, blond girl, white shirt, bright print shorts) This is a highly distressed child that the stranger tries to coax away from the door with toys, rather than just moving. Then the stranger moves her away from the door after it is opening.
33. (1:19:44, boy, black hair, white print shirt, blue and white print shorts) Another case of a stranger trying to distract a highly distressed child with toys rather than picking him up,

moving him away from the door, and trying to comfort or positioning him for reunion. Again, the stranger drags him away from the door after the knock and it is already opening.

34. (1:23:52, same child) Again, the stranger tries to distract him with toys, then she just moves him away from the door without trying to give him any comfort. Because of the way that she is holding onto him (under the arm, with him standing and straining hard away from her), he catapults himself to the door, hitting his head quite hard on the floor. This is one of the reasons that I recommend sitting children on the floor when they are highly distressed.
35. (9:54:28, girl, dark blond hair, blue coverall) The stranger moves this child in a rather rough, insensitive manner, but she does a good job of gradually releasing the child so that she doesn't fall when she heads for the door. She could have held onto her for just another second or so however.
36. (11:55, girl, brown hair, pink coverall) The stranger moves this child too close to the door and with her back to the camera, and then assists the child from her lap for the reunion and interacts with the mom.
37. (9:30:07, blond girl, light top and pants) The stranger does a very good job of allowing the child to remain on her lap for the reunion. Although she looks around a little more than we like, she becomes a very good chair.
38. (14:04, girl, dark blond hair, white blouse, blue jeans) The stranger moves as the child is reaching for mom and the child turns around and looks. This is frustrating for the coders

- because it seems that the stranger should have been out of the child's line of vision, but because the stranger was moving, we can't count the child's looking away behavior as avoidance.
39. (9:32:55, girl, white shirt, light blue pants) The stranger was too interactive after the knock.
 40. (09:05, girl, red print coverall) The stranger does a good job of not interacting with a child who is very initiatory toward her after the reunion. It probably would have been best if she had left at 9:30, after the child had first offered her a toy.
 41. (15:58:22, girl, white blouse, light blue overalls) Another example of a stranger not responding at all when the child tries to initiate interaction after reunion. (Not NICHD sample.)
 42. (12:50, boy, dark blond hair, red shirt, print pants) The stranger should have sat on the floor with the child before nodding for mom to return. Since she nodded while standing, she is caught standing and holding the child for reunion. She does a very good job of allowing the child to make his wishes known before releasing him.

Leaving after Reunions

Although our general rule for strangers leaving is to exit about 30 seconds after the mom returns, there are exceptions to this. Generally, with highly distressed children, it is better to leave sooner rather than later. If the child is crying and being held by the mom, you can usually leave in about 10-15 seconds. If

you end up positioned quite close to the mom and child (and feel like you should return to your chair), leave.

With children who have not shown much reaction to mom's return, it is more difficult to judge when to leave. If the child seems to be back to play and is not looking toward mom, this is a good time to leave.

43. (19:39, boy, light brown hair, white t-shirt, dark pants and suspenders) Although the mom has returned to her chair (and it should be OK to leave), the stranger leaves just as the child is making his initial approach to mom.

44. (11:14, boy, red hair, plaid shirt, beige shorts-overalls) This is a highly distressed child and the stranger ends up positioned quite close to the mother-child pair. The child looks at the stranger several times, and the mom tried to talk to the stranger also. The stranger should have left almost immediately (10-15 seconds), instead, she stays for almost 1 1/2 minutes.

Talking To Moms During Reunions

Whenever possible, stranger should not talk to moms during reunions (the previous tape was a good example of not responding to mom), especially if the mom is just making general conversation or chatting. If the mom asks a specific question, reply with a general answer like: "Just do whatever you are comfortable with." Do not give specific instruction like "Sit in your chair," or "Pick up your child." If the mom has a specific concern about something else (perhaps a dirty diaper), tell her that you'll talk to the VC

about it and then leave. The VC should make the decision of whether or not to interrupt or discontinue the procedure.

45. (11:36:49, boy, black curly hair, light blue sweats outfit)
You need to listen closely to this tape, but the stranger instructs the mom to "Get back up on the chair when you get the chance." at 11:37:08. This is an inappropriate instruction for the stranger to give the mom during a reunion.
46. (10:07:22, blond boy, white print romper) This mom asks "Do you want me to go sit down?" The stranger responds with an affirmative "Um hm." Again, a general response of "Whatever you're comfortable with," is a better choice.

Abbreviated 6/7 Separations

As a general rule, strangers should be ready to enter the room as moms leave for the second separation. Frequently, moms fail to leave quickly enough and the children get out. Rather than having moms try to return the child and leave again, it is better to have the stranger return the child to the room. This should be done as quickly as possible.

47. (1:16:00, blond boy, blue tank top, black shorts) The stranger correctly returns the child to the room when he gets out when mom leaves for the second separation. If the mom would have been faster in closing the door, there could have been an episode 6.
48. (12:42, blond boy, green shirt, red print overalls) Mom is unable to leave without the child and the stranger is not there to bring him back to the room. This procedure is

eventually ended early and rescheduled, but the situation could have been eliminated if the stranger had been prepared to return the child to the room.

49. (9:56:50, child, brown hair, red shirt, blue overalls) The child gets out with the mom and the stranger tricks the child back into the room with "Lets go play," and then shuts the door behind the child. Even if you can get the child back into the room, do not do this. If the child gets out with mom, have the stranger return with the child.
50. (10:05:50, girl, brown hair, red blouse, white poka-dot pants) This is a child who hasn't calmed down from the first reunion and who doesn't need to have a second separation and reunion to be classifiable. But, if you're uncertain and try to do the second separation, the stranger needs to explain the procedure to the mom and then assertively take the child from the mom (he who hesitates is lost). If you fail on your first attempt to take the child, discontinue the procedure and immediately send the tape to the coders (with a separate note) so that they can determine if it needs to be rescheduled.
51. (11:45, blond girl, white print shirt, gray pants) The stranger does a nice job of making sure that the mom understands the procedure and holds onto the child once she has decided to take her, even though the child immediately becomes distressed and wants to stay with mom.

CHAPTER 17

SECTION 3.1

CODING MANUAL FOR THE STRANGE SITUATION

ASSESSMENT OF PATTERNS OF ATTACHMENT

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CHAPTER 17

SECTION 3.1

CODING MANUAL FOR THE STRANGE SITUATION ASSESSMENT OF PATTERNS OF ATTACHMENT

I. OVERVIEW

The coding manual for the NICHD Study of Early Child Care incorporates the instructions described in Ainsworth, Blehar, Waters & Wall (1978) Patterns of Attachment for coding interactive behaviors and classifying infants into secure or insecure categories. The manual also relies on Main and Solomon's (1990) chapter "Procedures for Identifying Infants as Disorganized/Disoriented During the Ainsworth Strange Situation." The manual, essentially, consists of photocopies from these two sources. In addition, Ainsworth will contribute updated notes on her coding procedures.

Coders will be trained extensively to watch the Strange Situation tapes and use the manual to complete a coding sheet on each subject. A draft of the coding sheet is included in the Appendix of Section 17.3.1.

II. CODING PLAN

The biggest threat to completing the Strange Situation task on time is coder burn-out. This would necessitate retraining, which would take 3 months, including testing for reliability on 50 tapes. Therefore, a small group of coders (4) all of whom will work 20 hours/week and receive benefits will be used. This plan incorporates the fact that Seattle will also code the solitary play episodes for sustained attention and level of play. This plan has the same coders doing each scheme (though not on the same children). The schemes are quite different and will give coders a break from just one kind of concentration. Coders will have to work at least 5 days a week, as I would not want them to plan on looking at videos for more than 4 hours. In reality there will be breaks and conferences, so it will be less.

One of the four coders will be "head coder" who will be responsible for supervising the others in terms of scheduling coding time and conferences, and reporting back to Sue Spieker. Sue Spieker also plans to code on a regular basis to keep in touch with the data. She will plan to be available to conference the most difficult tapes, to make decisions on their codability, etc. The budget permits the head coder to start in January and others to start in February for training.

This coding plan assumes:

All Strange Situation and Solitary Play coding will be done in Seattle.

Coding will begin May 4, 1992 and proceed for 60 weeks,

ending July 1, 1993. Four coders will be hired. All will code both episodes. No coder will code the solitary play and Strange Situation episodes for a single child.

STRANGE SITUATION (each "pass" takes 2 hours)

1200 passes for initial coding
300 for random reliability
300 for first level conferencing
120 for second level conferencing

1920 passes X 2 hours = 3840 hours

PLAY

1200 passes
300 reliability

1500 passes X 45 minutes = about 1200 hours

TOTAL

3840 + 1200 = 5040 hours/60 weeks = 84 coding hours/week
equals four coders @ 20 hours/week
plus Spieker @ 4 hours/week

III. CODER TRAINING

Training will begin February 3 and last 13 weeks for a total of 208 hours devoted to Strange Situation. Training under the direction of Susan Spieker consists of:

Reading and lectures	8 hours
Watch and discuss 40 tapes	40 hours
25 pre-test tapes & discussion	60 hours
50 reliability tapes	100 hours

IV. TRAINING FOR THE ADMINISTRATION OF THE STRANGE SITUATION

Each site should have a resident Strange Situation expert with thorough training in three roles: Visit Coordinator, Stranger, and Camera Operator. In addition, this person should have a rudimentary idea of how the assessments are coded. This will enable him/her to make appropriate decisions when difficult moments arise during the assessments. The resident expert should, ideally, have the practicing role of the Visit Coordinator. This will keep the expert close to the data.

Training for the Strange Situation could be accomplished in one day. Below is a sample agenda.

Prior to the training session, participants will have thoroughly read the operations manual. (Ideally they will have done some pre-piloting as well.) They should have read the coding manual, and one review article on attachment (perhaps Bretherton, 1985).

Day 1

8:30-9:00 Get together

9:00-11:00 Overview of Strange Situation and attachment theory: historical development; attachment-exploration balance in infancy; classification of attachment patterns; introduction to key personnel: Visit Coordinator, Stranger, Camera Operator; description of what each does

11:00-11:30 break

11:30-12:30 Camera Operator training; discuss selecting and training camera operators back at the sites;

12:30-1:30 Lunch

1:30-4:00 Stranger training; discuss selecting and training of Strangers back at the sites; view 4 tapes and discuss stranger's behavior; trouble shooting--discuss problem situations and appropriate Stranger response

4:00-5:30 Visit Coordinator: putting it all together
Review role of Visit Coordinator; go over scripts and procedural details like scheduling, siblings, time of day, etc; discuss decision making in a crisis; critique 1 or 2 tapes for Visit Coordinator's role in directing Stranger, Mother and Camera Operator

V. CODING MANUAL FOR THE STRANGE SITUATION

Attachment classifications for the A B C categories will be made according to Ainsworth et al. (1978)¹. Scoring for disorganization/disorientation will be done according to procedures described by Main & Solomon, (1990)². Selections from these references follow.

¹ Ainsworth, M.D.S., Blehar, M.C., Waters, E., & Wall, S. (1978). *Patterns of Attachment*. Hillsdale, N.J.: Lawrence Erlbaum.

² Main, M. & Solomon, J. (1990). "Procedures for Identifying infants as Disorganized/disoriented during the Ainsworth Strange Situation." In M.T. Greenberg, D. Cicchetti, & E.M. Cummings (Eds.), *Attachment in the Preschool Years*. Chicago: The University of Chicago Press. pp 121-182.

CHAPTER 17

SECTION 4

SNACK

The purpose of the snack is to give the mother and child a break after the possible stress of the Strange Situation. Initial descriptions for this procedure were developed by Cathryn Booth. Revisions to the procedure were made by Deborah Vandell following comments and piloting by Temple, Pittsburgh, Washington, Wisconsin, and Western Carolina.

I. MATERIALS

- A. An adult-sized chair
- B. A child size table and chair
- C. A plastic container with a lid containing:
 - a. child cup with lid
 - b. paper cup for the mother
 - c. Cheerios in a small Tupperware container
 - d. one individually wrapped slice of American cheese
 - e. several crackers in a small Tupperware container
 - f. napkins
- D. Bottle of unsugared apple juice (enough for mother and child)
- E. Baby wipes for cleanup

II. PROCEDURE

When the visit coordinator enters the room, she should quickly clear away the strange situation toys and then bring the child sized table and chair and the snack box into the room. Say to the mother,

"Now it's time to take a break and have a snack. I have a table and chair here for CHILD." Then say, "Here's the snack in this box. Go ahead and have some yourself. Let me know when you're finished."

After bringing the snack into the room, the visit coordinator should quickly leave. The snack segment can continue until the mother and child have finished or for 10 minutes. Begin timing the snack after the visit coordinator leaves the room. The visit coordinator should observe the snack from behind the one way glass. When it appears that the snack is finished, he/she should go in to the room and remove the remains of the snack. Leave the table and chair in position, because they will be used in the next activity, the Bayley. If 10 minutes have elapsed, the visit coordinator should encourage the mother to "finish up" so that the visit does not become too long.

Although there are no current plans to code the snack as part of the common protocol, all sites should videotape the snack session. Simply continue videotaping the children with their mothers after the Strange Situation has ended. During the snack, the video image should include both mother and child. The table and chairs for the snack should be arranged so as to maximize the opportunity to have both the mother's and the child's faces on the screen as well as bodies. If it is not possible to get both mother and child on the screen, focus on the child with regular "scans" back to the mother. While filming, adjust the lens so that the images of mother and child fill most of the screen. Pictures of the carpet or the cracker will not help coders in the future!

CHAPTER 17

SECTION 5

15 MONTH BAYLEY SCALES OF INFANT DEVELOPMENT (MDI)

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CHAPTER 17

SECTION 5

15 MONTH BAYLEY SCALES OF INFANT DEVELOPMENT

I. OVERVIEW

The Manual for the Bayley Scales of Infant Development (Psychological Corporation) is quite comprehensive. The manual in current use was published in 1969. There is a 1984 supplement. These materials will serve as the basic manual for administration of the Bayley mental scale. Included here is a description of training, certification of examiners, and special administration instructions.

Each site needs to order a current Bayley kit and MDI forms from Psychological Corporation (1-800-228-0752). In addition to the kit, you need sheets of blank paper (newsprint or photo copying paper, not heavy bond paper), tissues, and a stop watch. Organize the test items into plastic containers for ease of access during the test.

II. PREPARATION FOR THE TRAINING

Visit coordinators should begin preparation for the training three months ahead of time. The following steps should be taken:

1. Read the manual several times. IT IS REALLY IMPORTANT THAT YOU KNOW THIS TEST BACKWARDS AND FORWARDS. Chapter 1 gives an introduction to the test. Pay particular attention to page 5,

The Training of Examiners. Chapters 2 and 3 concern Standardization and Other Statistical Information. Examiners should be familiar with this sort of psychometric information. Chapter 4 concerns General Testing Considerations. Pay particular attention to the sections that begin on page 25 (Rapport and the Order of Testing) and page 27 (Cautions for New Examiners). In addition, it is important that examiners understand the concepts of basal level and ceiling scores. Chapter 5 concerns Directions for Administration of the Mental Scale. This chapter describes how to administer each item. You need to know how to administer each and every item. We will be able to obtain basal and ceiling scores for most children with items 100-135.

2. Before the training, visit coordinators in training should observe a skilled examiner administer the Bayley to a 12-18 month old.

3. Before the training, each visit coordinator should administer 8-10 practice tests to 12-18 month olds, preferably while being observed by a trained examiner.

4. In addition, examiners in training should thoroughly review the videotape of Bayleys provided by the Kansas site, and check their scoring against the master scoring included with the tape.

III. TRAINING

Before coming to the training session, examiners should

administer and score 8 to 10 Bayley tests each to children ranging in age from 12 to 18 months. If two examiners are training together (the recommended procedure), this means a total of 20 Bayley tests, with each trainee administering 10 and observing 10. If a skilled examiner is available at your site, he or she should observe each trainee or review tapes of one or two of the sessions.

IV. AFTER THE TRAINING

After the training, visit coordinators will videotape themselves administering the MDI to two 15-month-olds. These tapes and the accompanying score sheets should be sent to the Kansas site by March 15, 1992. Based on those tapes, a visit coordinator will be judged by trained personnel at Kansas as either certified or not certified. Visit coordinators who are not certified will be given feedback, and will need to submit two additional tapes for certification. If new visit coordinators are added during data collection, they must submit tapes for certification prior to conducting lab visit.

V. ADMINISTERING THE BAYLEY

The MDI will be administered after the snack in the playroom

B. All the toys and materials not needed for the Bayley should be removed from the playroom before beginning the testing. The test should be given with the child seated at a play/feeding table or high chair with a large tray. The child's seat should

be adjusted so that child and tester are at the same height, and the seat belt should be fastened. The tester sits directly facing the child. The mother should sit to the side, as close to the child as she wishes.

It is acceptable for the examiner to ask the mother to present items to the child. In the initial instructions to the mother, however, the tester will tell her that she should not intervene unless asked to do so. In general, the mother should not be asked to participate in the Bayley until the tester has presented and scored the entire test. At that time, if the tester feels the child might perform certain items with participation by the mother, the tester can involve her.

If a child becomes distressed when placed in the chair, the tester should first try to distract the child with an interesting toy from the Bayley kit (the bell, car, or squeak doll can be tried). If the child is too distressed to sit in the chair, the child should be tested seated on the mother's lap. For these situations, you need an adult-height table that is approximately 2 feet wide and 4 feet long. When the child sits on the mother's lap, his or her elbows should be just at table-top height. Again, the tester should sit directly across the table from the child, facing the child. Be direct with the mother about keeping the child at the table, and ask her not to put the child down. If the child is very restless, you may have to present items more quickly than normally. Try to avoid having the child running around the room between tasks.

VI. INSTRUCTIONS TO MOTHERS

Give instructions to mothers while you are placing the child in the seat. Be sure there is something attractive for the child to hold and play with on the tray. This does not have to be an item from the Bayley kit, but can be another small attractive toy. If you wish, you can place a few blocks on the tray and observe what the child does with them incidentally.

Tell the mother:

"Next I will be giving CHILD some toys and watching what (he/she) does with them. Sometimes I will ask (him/her) to do specific things with the toys. For example, I will ask (him/her) to put cubes in a cup, to put some pegs in a board, and to name some objects. Some of the things I'll ask will be easy, some will be too hard, and some will be just right. We use this range of tasks so we can find out all the things CHILD is doing right now. While we're doing this, please try not to talk to CHILD because I want (him/her) to pay attention to me. This may be hard for you, especially if (he/she) doesn't do something you know (he/she) can do. I'll be asking you about things like that when we're finished. I think you will really enjoy watching CHILD while we do this."

If you find you must test the child on the mother's lap, also say:

"It's important that CHILD stay on your lap at the table.

You can bounce (him/her) and give hugs to help keep

(him/her) comfortable, but please try not to say anything and don't let (him/her) down until we're done."

VII. SCORING

Use the standard MDI score sheets for scoring. Record P (pass) and F (fail) for each item rather than checkmarks, because checks can easily be placed in the wrong column.

The Other column is used to record omission (O), refusals by the child (R), and items failed that the mother reports the child can do (RPT). Omissions should be rare. A child is considered to refuse an item only if he or she makes no attempt at all to manipulate the objects offered, i.e., turns away without touching the objects, immediately shoves them away, or throws them. If the child makes even a brief attempt and then pushes objects away, the item is scored as a failure.

At the end of the session, ask the mother if the child's behavior was typical, and if she noticed anything the child did not do that he or she would normally do. Record these as RPT, but score them as failures.

Incidental observations. Any behavior of the child that you observe during the lab session can be scored as part of the Bayley. The tester can not accept other people's reports (even other study personnel), but can credit any performance he or she observes. Thus, it is useful for the tester to observe as much of the lab visit as possible. Several of the Bayley items, especially language items, can be observed incidentally prior to

the actual testing situation. These items do not have to be readministered during the test.

Determining basal and ceiling levels. Refer to the Bayley manual (pp. 29-30) for a discussion of basal and ceiling levels. for the purposes of this study, examiners will be expected to administer enough items to show 10 successive items passed prior to the first failure, and 10 successive items failed after the last pass. If a child has shown exceptional performance on a single task (such as the pegboard or blue board) that results in his or her passing an item above his or her own ceiling, it is not necessary to continue testing beyond establishment of the ceiling. Be sure to mark all items passed, even if they are above ceiling.

Calculating raw scores and MDI. The child's total score and standard score will be calculated at the Data Coordinating Center. Testers are responsible for making sure every item between the basal and ceiling is marked correctly. Original score sheets, clearly labeled with the subjects ID and tester ID, should be sent to the Data Center, with copies kept at the site in the family's confidential folder.

VIII. TROUBLESHOOTING

1. Child refuses to complete task.

The Bayley manual (page 26) is clear in its directive to be responsive to the child. The best way to deal with this situation is to be sensitive to the child and her/his state. The

visit coordinator can try enticing the child with different materials, but when all else fails, a break in the testing is recommended. The child can then be brought back to the table with a novel toy from the testing.

2. Child looks to mother for help.

Before the testing you will have cued the mother that there will be some tasks that the child will not be able to do.

Furthermore, you will have told her that she should not assist unless asked to do so by you. A reassuring "You do it" said to the child by the examiner may help the child along.

3. Child cries for the material from a previous item.

Again, the best approach is to avoid this by bringing out the next material as you take away the old. If a child becomes very attached to one toy, it is acceptable to let the child hold it, or leave it sitting on the tray where the child can see it, while you administer other items.

4. Mother talks nonstop at the child telling him/her how to do the item.

Before the testing, you will have emphasized that you do not expect the child to do all tasks presented. If the mother begins to constantly direct the child, you must gently remind her of that expectation. You can say, "We know it's harder for children to do everything they know how to do in this situation. We need to see what (he/she) does without your help, then in a few minutes I'll ask you to help."

5. Mother insists the child can do something that s/he has

just failed to do.

Explain to the mother that you are interested in the child's performance in the lab with you and that you realize that you won't necessarily see the child's very best performance. You might also explain that the test takes this into account.

Provide other reassurances, if the mother seems to need them (e.g., the child is doing well or mention a specific item the child did and enjoyed.

6. Mother asks you what the child's IQ is.

Explain that the test doesn't measure IQ (which is true). If the child is passing all the typical items, you can say "(He/she) seems to be just about on target with other children her age." Even better you can simply share with the mother your perception of what the child enjoyed during the test. "(He/She) really enjoyed looking at the book. Do you look at books at home a lot?" This often refocuses the mother's attention away from performance and onto the child's interests, and also conveys your enjoyment of the child as an individual.

7. Child appears to perform poorly.

If you believe a child is noticeably below the typical range, or shows unusual behavior during the Bayley or any other part of the lab session, discuss your concerns with the site coordinator or PI. The PI will decide if the parent should be contacted further.

8. Child speaks and understands a language other than English.

If children are not learning English as their first language, the Bayley is inappropriate and should not be administered. Record this as missing data.

See the Manual for the Bayley Scales of Infant Development for further instructions.

CHAPTER 17

SECTION 6

OPERATIONS MANUAL: 15-MONTH GROWTH MEASURES

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Acknowledgement: This manual was prepared collaboratively by Drs. Sarah Friedman and Peter Scheidt and was based on a manual from the Infant Health and Development Project, provided by Dr. Robert Bradley.

CHAPTER 17

SECTION 6

OPERATIONS MANUAL: 15-MONTH GROWTH MEASURES

I. OVERVIEW

The manual includes information about the following:

- o Rationale for measuring weight and length
- o The procedure: timing, location, set-up and order
- o Instructions to the mother
- o Maintaining rapport with the child during the session.
- o Equipment and procedures for its calibration and repair
- o Procedures for measuring weight
- o Procedures for measuring length
- o Form for equipment calibration
- o Form for recording 15 months weight and length
- o Training of visit coordinators

II. RATIONALE

Physical growth as measured by weight and length (or height) are essential indicators of health and nutritional status of young children. An appropriate rate of growth in both weight and length (or height) can serve as a rough indicator of physical well being and of adequate nutrition.

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An inappropriate rate of growth may suggest significant chronic disease. Consequently, growth measures are important dependent variables in this study of child development and are expected to be related to variations in the child rearing environments. More specifically, it is expected that in very poor quality rearing environments, children will be at risk for failure to thrive. Furthermore, differences among children in terms of growth parameters are expected to be related to the psychological outcomes of interest in the study. The patterns of interdependence between environment, growth and psychological function will be investigated.

III. THE PROCEDURE: TIMING, LOCATION, SET-UP AND ORDER

The procedure will take place at the very end of the 15 month laboratory visit, following the administration of the Bayley test. The child and mother will be brought into a room with a scale and a length measuring instrument placed on either a table or on the floor (the table top should accommodate both the scale and the length rule). The mother will be told that if she chooses to stand next to her child, she is welcome to do so.

The weight measurement will be performed first and the length measurement second, since the latter is the less pleasant one.

IV. INSTRUCTIONS TO THE MOTHER

Following the administration of the Bayley test, the child and the mother will be told that the very last procedure in this visit involves the weighing and measuring the length of the child, so we can tell how big he or she has become. The equipment will be shown and the procedures for weighing and measuring length will be explained to both mother and child. The mother will be told that at the end of the procedure she will receive a card showing how much her child weighs and how long he or she is. The mother will be told that she can either sit and relax or that she can stand to the side of the visit coordinator. It should be made clear that both options are fine, as far as the visit coordinator is concerned. The mother should not be encouraged to choose one plan of action (or inaction) over the other.

V. MAINTAINING RAPPORT WITH THE CHILD DURING THE SESSION

One of the challenges to performing anthropometry on the 15-month old child will be to accomplish the task accurately without producing a physical struggle, a crying child, or an embarrassed parent. The visit coordinator's general approach to the child can help gain his/her confidence and dispel his/her fears.

Since it will be necessary to have the child undressed down to tee shirt and diaper to obtain the weight,

this can be done by the mother or the child him/herself while the visit coordinator makes pleasant conversation with the mother. If the mother objects to having her child weighed in a tee shirt (or an equivalently light top) and diaper, the visit coordinator will note this on the Weight and Length Measurement form.

Prior to performing any of the measurements, each step should be explained simply to the child, and should be demonstrated if possible with a doll. When offering explanations, it is suggested that the visit coordinator should be close to the child and at approximately the same head-level as the child. This position makes the visit coordinator less threatening and helps establish rapport. For some children, it is helpful to allow them to touch or handle the equipment in order to make them feel more comfortable with the measuring process.

During weighing, if the child has a tendency to reach out and touch the scale, he/she should be given some place to put his/her hands, for example, on his/her hips or holding his/her own hands in front of his/her body. When it is time to measure the child, allow him/her to sit up briefly by the measuring board, to see where his/her head and feet will go, before having him/her lie down. Throughout the procedure, the child should receive praise and encouragement from the visit coordinator.

It is strongly advised that the visit coordinator

avoid asking the child for his/her permission to do the maneuvers, since the visit coordinator is planning to do them in any case. Rather, the visit coordinator will proceed patiently, pleasantly, but firmly, attempting to convey to the child that there is nothing to fear and that the visit coordinator fully expects the child's cooperation.

VI. EQUIPMENT AND PROCEDURES FOR ITS CALIBRATION, REPAIR AND SANITATION

The equipment for measuring weight and length is the same at each of the ten research sites. It needs to be calibrated following the same procedures in each site.

Scales for measuring weight

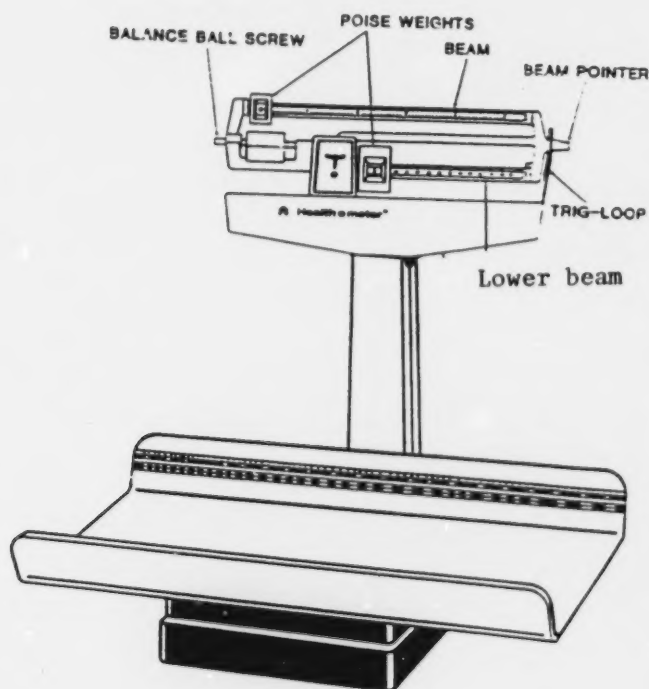
The scale to be used in this study is the Health O Meter Pediatric Balance Beam Scale Model 1522KL. A drawing of the scale is shown in Figure 1 as well as in the Assembly and Operating Instructions that each site received with the scale. Each scale is an infant two beam scale with freely sliding non-removable weights (or poises). The scale has a screw type zeroing adjustment. The lower beam, or main beam, can be rotated to mark gradations in either kilograms or pounds. For this study we will record weight in pounds and length (height) in inches. Therefore rotate the beam to indicate pounds. The upper beam, or fractional beam, should be marked by ounces. The scale should be placed on a firm



Health o meter[®]

PEDIATRIC BALANCE BEAM SCALE

MODEL: 1522KL



solid surface, preferably a table.

The calibration of the scale should be checked before beginning the 15-month assessments and every week thereafter to the end of the 15 months laboratory visits. Calibration will be done with a 25 lbs. standard weight provided by NICHD. To calibrate, zero balance the scale as described below. Place the 25 lbs. weight on the scale platform. Move the weight on the main beam away from zero until the indicator points just above the center. Gently move the weight on the fractional beam away from zero until the indicator is centered. It may be necessary to move this weight back and forth several times to center the indicator. The weight should register 25 lbs plus or minus 4 oz. on the scale.

Scale calibration should be checked by a site specific designated individual with the standard weight every week during the 15 month assessments. If you find that your scale is not accurately weighing the 25 lbs weight (25 lbs. plus or minus 4 oz.), contact a local scale distributor to have the scale professionally calibrated. It is essential that scales at all sites are properly calibrated in order for the data obtained to be comparable. The Scale Calibration form (14H) will be used to record the weekly calibrations (see appendix). Form 14H is then sent to the DCC after 22 weeks of calibration.

The zero balance of the scale should be checked at

the beginning of each laboratory visit day by a designated individual. To check the balance, place the weights on each beam at the zero position. There should be nothing resting on the scale platform except when a cloth is used for the child's comfort. When the scale is in balance, the indicator at the right end of the beams will be pointing to the exact center of the space provided. If the scale is not in balance, adjust the balance ball screw. Generally, only a fine adjustment is necessary. The scale is balanced when the indicator points to the exact center of the space provided.

Board for Measuring Length.

Length at 15 months will be measured on a infantometer rule. Each site is provided with a Health O Meter infantometer rule 17-1334 which measures up to 40 inches. Recumbent length (lying down) was chosen because it can be measured more accurately and reliably than standing height in 15 month old children and is the standard method for measurement for this age children.

The measuring board should be checked by the site's designated person each day it is to be used. The movable footboard should move freely but not wobble. We anticipate that with careful use, these length boards will remain in calibration throughout the 15-month assessments. Please handle your board with care and store it in a place where it

will not be disturbed. If the moving parts of your board become loose or it appears to be out of calibration, it should be repaired locally. If repair is not possible call either Sarah Friedman or Peter Scheidt at NICHD for instructions.

Sanitation

The scale should be covered with paper or wiped clean using soap and water after each child is measured. When measuring the length of the child, the child should be placed on a mat with a plastic surface that can be wiped clean using soap and water.

Mobiles

Having a mobile above the child's head when the child is weighed and measured will distract the child's attention and may facilitate the ease with which the procedure is carried out.

Doll

A doll will be used to show the child how he/she will be weighed and measured.

VII. PROCEDURES FOR MEASURING WEIGHT

To measure weight, follow these steps:

- 1) The child's mother should now be asked to undress

the child down to tee shirt and diapers. If the child wishes to try and undress with no help or with some help, this should be encouraged. If mother objects to having the child undressed, weigh the child with the minimal clothing approved by the mother and record on the Weight and Measurment form (14G) that the child was weighed in other than tee shirt and diaper/underpants.

2) The mother or the visit coordinator should explain to the child that we want to find out how big he/she is.

3) Set the weights on both beams to zero.

4) Place the child on the center of the platform seat of the scale. An interesting mobile placed above the scale may help focus attention of the child long enough to obtain the weight.

5) Move the weight on the main beam away from zero until the indicator points just above the center. Gently move the weight on the fractional beam away from zero until the indicator is centered. It may be necessary to move this weight back and forth several times to center the indicator. Read weight to the last completed unit.

6) Repeat the weight, taking the child off the scale and placing back on each time.

7) If the second measurement differs from the first by more than 4 ounces, record these weights and obtain two more weights according to the above procedure.

8) Remove the paper from the scale or clean the scale

after use.

VIII. PROCEDURES FOR MEASURING LENGTH

To measure length, follow these steps:

1) Place the child on the infantometer rule with his/her head on the big red dot snug against the fixed vertical area. (A dot will be placed at the head end of the board.)

2) Make sure that the child's legs are fully extended, knees together and toes pointed straight up. The visit coordinator should use one hand to stabilize the child's legs, holding them down against the board and maintaining the legs in the correct position. (A second person may be necessary to hold the legs and torso of an uncooperative child.)

3) With the other hand, the visit coordinator should bring the movable footboard to rest against the soles of the child's feet. The footboard should be pushed toward the feet with the whole hand. It should not be grasped by the upper edge and pulled toward the feet.

4) Check the child's position before reading the measurement. Be sure that the head is in the position described above, the body is straight, the legs extended and feet flat against the footboard. If a child's legs are different lengths, measure the longer leg.

5) Read length to the last completed unit. (1/8")

6) Obtain two length measurements verifying the proper position of the child as described above prior to each measurement. Move the movable footboard away from the soles of the child's feet between the two separate measurements.

7) If the second measurement differs from the first by more than 0.5 of an inch, record these lengths and obtain two more lengths according to the above procedure (moving the footboard away from the child's feet between measurements).

8) Wipe off the infantometer and the mat that the child was placed upon for measurement using soap and water.

IX. TRAINING OF VISIT COORDINATORS

Training of the visit coordinators was conducted by Sarah Friedman at the 15 month lab assessment training in Wisconsin. Sites will pilot the weighing and measuring procedures. This piloting will be videotaped and the tapes will be sent to Sarah Friedman and Peter Scheidt for review.

Chapter 18

ADMINISTRATION OF 15-MONTH CHILD-CARE VISITS

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ACKNOWLEDGEMENTS

The Child Care procedures were developed by several people. Deborah Phillips was primarily responsible for Profile, and interviews. Kathleen McCartney and Alison Clarke-Stewart were primarily responsible for behavioral observations and questionnaires. Deborah Vandell and Margaret Owen were primarily responsible for qualitative ratings. Alison Clarke-Stewart was also primarily responsible for the Mother Questionnaire about Child Care. Bettye Caldwell was responsible for the Child-Care HOME measure. Alison Clarke-Stewart was the chair of the 15-month Child-care Subcommittee.

Chapter 18

ADMINISTRATION OF CHILD-CARE VISITS (15 MONTHS)

I. PURPOSE OF THIS CHAPTER

This chapter provides guidelines for the child-care assessment visits to assure that these visits are conducted in a standard way across the ten sites participating in the NICHD Study of Early Child Care. In addition, it will serve as the archival description of the methods used in the child-care data collection.

It is vital to the success of the Study that the interview and observational data be collected in as identical a fashion as possible across sites. In this chapter, you will find suggestions about how to interpret both interview and observation items, as well as how to administer the interview and collect the observational data. These procedures must be followed by all research assistants to ensure the comparability of the data across sites.

We have attempted to consider as many questions and contingencies as possible. However, situations that we have not anticipated will arise during the course of data collection. When you are presented with a situation that is not covered in the manual, capture it as accurately as possible (e.g., write the caregiver's exact question about an interview item), then contact your PI or Kaye Fendt at the Data Coordinating Center. She will

confer with the relevant individuals and give you a coding decision, an interpretational decision, or whatever is needed. These responses will be distributed to all sites by e-mail. Each of these new decisions will then be recorded in an appendix to this manual that will also be distributed to all sites.

II. RECRUITMENT PROCEDURES

The overall recruitment strategy for child-care providers is based on a set of common guidelines and procedures. Within these, flexibility and multiple approaches will undoubtedly be necessary. These procedures are described, in detail, in Chapter 13, Administration Manual for the Thirteen-Month Phone Interview.

This chapter picks up the process at the point that the provider/director is contacted. In general, the common guidelines are, first, to ask the mother during the 13-month phone call for permission for us to contact the child-care provider directly, and, second, to ask the mother to contact/persuade the caregiver if our attempt to get the mother's permission to make the first call fails or if our first attempt to obtain the caregiver's consent to visit is unsuccessful.

A. Child-Care Recruitment

1. General Approach

You must first determine whether the target child has a primary provider and, if so, the identity of this provider. This information is contained in the 13-month telephone interview data. IF THERE IS NO PRIMARY PROVIDER, THERE WILL BE NO CHILD-CARE VISIT. If there is a primary provider, invoke the scheduling procedures for centers and homes (including care in the child's own home or another home, by a relative or non-relative), described below. This should be done as soon as possible after the 13-month telephone interview is completed. The windows for all the 15-Month procedures are given below.

Use one of two approaches to contacting the provider. The preferred approach is to contact the primary child-care provider (homes) or director (centers) directly. The alternative approach is to have the mother contact the provider/director prior to your contact.

In your scheduling call, explain the visit, answer any questions, obtain an initial verbal consent, and schedule 2 visits. (Center directors will also be given a telephone interview at this call - see center recruitment, below.) The windows for the two 15-month child-care visits are as follows:

The windows for each visit at 15-Months are as follows:

Visit	Ideal Time	Regular Window	Exception Period
15 Month Child C. Visit	The Week Before 15-Months	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
15 Month Lab Visit	The Week Before 15-Months	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
15 Month Home Visit	The Week Before the Lab	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days

All data collected during the exception period must have the prior written approval of a principal investigator. Fill out the EXCEPTION PERIOD DATA COLLECTION APPROVAL Form DM-G, and have the principal investigator sign it. See Chapter 14 for more information on this form. Because of the danger of cancellations all visits should be scheduled as early in the window as possible.

Other scheduling constraints for the child-care visits are:

- ♦ First child-care visit should be within 1 month of the home visit, and preferably within 2 weeks.
- ♦ Second child-care visit should be within 2 weeks of the first visit, and preferably 1 week later.
- ♦ Do not schedule any visits before the target child has been enrolled in the arrangement for at least two weeks.

Thank the provider/director for being part of the study and mail out the appointment confirmation letter, the description of

the study and visits, and, if required at your site, the consent form. Also mail Center directors the Director Questionnaire (see Center Recruitment, below). Some sites may wish to send out the description of the study and these visits between the completion of the 13-month phone call and the child-care visitor's initial contact of the provider.

If you cannot reach the provider/director by phone, send the RECRUITMENT letter and STUDY DESCRIPTION. Then follow-up with another call or ask the mother to have the provider call you.

The day before the first scheduled appointment, call the provider/director to confirm the visit.

If the provider/director refuses a visit, information about the arrangement should be obtained through a telephone interview with the director (centers) or mother (MOTHER INTERVIEW FOR CHILD CARE WE CANNOT VISIT).

2. Contacting the Director of Center-Based Care

- STEP 1 Child-care coordinator (or person responsible for scheduling child-care visits) contacts the center director OR mother contacts the center director.
- STEP 1B IF MOTHER CONTACTS DIRECTOR, coordinator recontacts mother for update, then contacts director.
- STEP 2 Coordinator schedules 2 visits and asks the director to inform all classroom staff who provide care for target

child about the study and the timing of the visit OR follows director's advice to contact the staff directly.

- STEP 3 Conduct the Director Telephone Interview.
- STEP 4 Send (a) letter confirming the visits, (b) Study Description, and (c) Director Questionnaire. If required at your site, also send the consent form.
- STEP 5 Call director the day before the actual observation to reconfirm the visit. Remind him/her to complete the Director Questionnaire.

IF THE DIRECTOR REFUSES THE VISIT, ask his/her permission to conduct the "DIRECTOR TELEPHONE INTERVIEW FOR CENTERS WE CANNOT VISIT." If he/she refuses, use the comparable mother Interview.

**3. Contacting the Provider of Home-Based Care
(Including In-Home Care by Fathers and Other
Relatives)**

- STEP 1 Child-care coordinator (or person responsible for scheduling child-care visits) contacts the provider OR mother contacts the provider.
- STEP 1B IF MOTHER CONTACTS PROVIDER, coordinator recontacts mother for update, then contacts provider.
- STEP 2 Coordinator schedules two visits with provider

STEP 3 Send (a) letter confirming the visits and (b) study description. If required at your site, also send the consent form.

STEP 4 Call provider the day before the actual observation to reconfirm the visit.

IF THE PROVIDER REFUSES THE VISIT, conduct the "Mother Telephone Interview about Child-care for Home Arrangements we Cannot Visit," Form 11C.

The following two sections - CENTER RECRUITMENT and HOME RECRUITMENT - elaborate these procedures for these differing types of arrangements. In some cases, it will not be clear whether an arrangement is a center or home. Consider it a home if the setting is used as a residence, even if it resembles a center in room arrangements, number of children, etc. This will often be considered a "Group Family Day Care Home" by licensing officials.

B. Center Recruitment

1. Contacting the Director

Contact the center director by phone as soon as possible after getting information about the child's care arrangement from the mother or after the mother contacts the director. If your site prefers to send the literature to the director and then make the phone call, that is allowable. But be aware of the window

for the child-care assessment (1 month prior to and 1 month after the child's 15-month birthday). In the phone call, briefly explain the study, summarize what is involved on the director's and teachers' parts, answer any questions, and obtain an initial verbal consent. Also explain to the director that all of the staff, who provide care for the target child need to be informed about the study and they will need to sign the consent form. Offer two approaches: the director may contact the staff or you may contact them directly. Do what the director suggests. If you cannot reach the director by phone, send the RECRUITMENT LETTER AND STUDY DESCRIPTION and follow up with another call or ask the mother to have the director call us.

If the director says "no" at this point, try to find out why. You may be able to assuage his/her concerns. Ask if you might send the materials (RECRUITMENT LETTER AND STUDY DESCRIPTION) and call him/her back. Ask if you may just ask a few questions over the phone either now or later (preferably now). Explain that it will take about 15 minutes (see below: 3. When it is not possible to do the Child-care Assessment).

In addition, in cases of refusal, if the child has a secondary arrangement in which he/she is enrolled for at least 10 hours a week, call the mother back and ask if we can repeat the recruitment process for this provider.

Following is a list of "talking points" for Child-care Recruitment. Adapt these points, as necessary, for centers you have already visited.

1. Explain the overall purpose of the study, using the consent form as a guide. For example: children are growing up under very different circumstances today; child care has become a very important part of most children's lives; we need to understand how this affects children's development; etc. Note national significance, importance to children and families, child-care providers etc.
2. Describe the visit from the provider's perspective:
 - a. Two days of visits;
 - b. Three hours each;
 - c. Prefer mornings, if target child is typically awake then;
 - d. We will start by talking briefly with director, and then go immediately to the target child's classroom;
 - e. Most of our time will be spent observing the target child. THIS DOES NOT REQUIRE ANY CHANGES IN YOUR TYPICAL ACTIVITIES. In fact, we don't want anything unusual to happen;
 - f. We will also be observing the target child's classroom; and,
 - g. We will interview up to 2 of the child's providers (about 30 minutes each).

3. All procedures will be maximally convenient for the provider (we can be flexible).
4. All data are confidential. (Nothing is reported to any licensing agency; our purpose is research, not evaluation.) The only thing we would need to report is child abuse.
5. We will be paying \$40 for his/her/their participation. (In cases of multiple providers, find out how the director would like this to work, e.g., divide among providers, program gift, etc.)
6. Complete TELEPHONE INTERVIEW, with the director.
7. Again, stress the importance that he/she talk to his/her staff who take care of the target child. You may need to volunteer to visit in advance.

The following is a sample telephone script, to be used with centers, that includes the points mentioned above:

Script for Caregiver Phone Call (Center Care)

"Hi. My name is _____. I am on the staff of the NICHD Study of Early Child Care. CHILD'S NAME who attends your center has been part of our study since birth. If you have already visited the center, say, "You may remember that we observed CHILD at your center when he was 6 months old." or "You may remember we recently observed OTHER CHILD..." I sent you a letter last week describing the study. Did you receive it?

IF DIRECTOR DID NOT RECEIVE THE INFORMATION, THEN DESCRIBE THE STUDY. The study seeks to learn how different people and places affect children's development. Because child care is such an important part of many children's lives, we want to observe children in their child-care setting. Children in the study are visited in their homes and child-care settings when they are 6, 15, 24, and 36 months old. I would like to come to observe CHILD at your center when he/she is about 15 months old.

Let me give you an overview of what I would like to do. When CHILD is about 15 months old, I would like to visit your center for a couple of mornings. The first morning I would start by talking briefly with you (director) and going over your answers to a brief questionnaire that I will have sent you ahead of time. (It just asks a few questions about the center.) I would then go to CHILD'S room. Most of my time in the room would be spent observing CHILD. This would not require any changes in his/her room's typical activities. I would also interview (for about 30 minutes) a maximum of 2 of CHILD'S providers. Finally, I would leave some brief questionnaires for them to fill out.

Of course, all information we collect is confidential. We are not part of any licensing agency.

In appreciation for your participation in this project, we would like to provide your program with \$40. It can be divided among the child's providers or donated as a gift to the program, whichever you prefer.

May I schedule these visits?

IF YES, Do you know CHILD's schedule well enough, or should I talk with someone else? I need to come at a time when CHILD will be awake for about two hours. I would like to come in the mornings, if possible.

SCHEDULE VISIT IF POSSIBLE.

IF NO, Would you like for me to send you additional information about the study? SEE TROUBLE SHOOTING SECTION.

I will be sending you some information to look over and also a letter confirming the visit dates and times.

Also, I'd like to get a little information about CHILD's room before I come. START DIRECTOR TELEPHONE INTERVIEW

(See section III C.1. for further information about
administering this interview.)

Thank you for your time.

2. Scheduling the Visit

If the director says "yes", schedule a visit, using the following questions:

(1) When you are speaking to the director of a center, ask if she knows the child's schedule well enough to be able to schedule the visit; if not, ask if you should speak to the child's caregiver to get the best times. Also ask the director the questions on the DIRECTOR TELEPHONE INTERVIEW. Then, ask the appropriate individual, "In your opinion, considering your schedule and the CHILD'S, what would be the best time for us to schedule a visit? I need to see the CHILD when he/she is most likely to be awake and not likely to be interrupted by someone coming to visit (for example, the mother coming to feed him/her). I will need to make two visits of about three hours each."

The child is most likely to be awake and available in the morning, so if you have a choice, please schedule the visit so that it occurs predominantly during the morning hours. Of course, some children will not be in child care at all during the morning.

(2) What day of the week is best for you? Do not observe children until they have been in the center (and the same classroom) for at least 2 weeks. Aim for as close to the child's 15-month birthday as possible, give or take

1 month. It is extremely important that the child-care visit be scheduled within this 2-month window. Between 16 months 0 days and 19 months 0 days, 15 month visits may be conducted, but flagged as exceptions. After 19 months 0 days, a 15-month child-care visit is not conducted. But it is essential to make every effort to schedule the visit within the two-month window.

You should aim for the second child-care visit to be within 2 weeks of the first child-care visit, preferably one week apart. The first child-care visit should be within 1 month of the home visit, if possible; preferably within 2 weeks. Schedule the visit at a time that the child's REGULAR caregiver(s) will be there. (Accept no substitutes!) If the regular caregiver is absent on one visit it will have to be rescheduled.

(3) Select times and dates for the two visits, and include this information in the confirmation letter to the director.

Thank the director for being a part of the study and tell him/her that:

(1) You will call back the day of the visit to confirm the appointment and to make sure the child is there;

(2) The director should receive, before your visit, a letter confirming dates and times of the visits and a description

of the Study and the visits. Tell the center director that he/she can post this description for parents to see, if he/she wishes;

(3) If your site requires that a consent form be sent in advance, tell him/her that this also will be included with the letter.

(4) He/she will also receive, with the letter, a brief questionnaire (DIRECTOR QUESTIONNAIRE) that you would like him/her to fill out before the visit. Explain how to fill out the questionnaire. If the Director has been visited within the past 4 months, you will use the SHORT FORM of the DIRECTOR'S QUESTIONNAIRE.

(5) Make sure that the director will communicate the information about the visit to the staff in the child's room. Offer to talk directly to the staff before the visit if he/she thinks this would be wise. Remind him/her that these staff will need to sign the consent form, along with the director, in order for you to collect any data.

You will then send:

- (1) the confirmation letter;
- (2) the description of the Study and visits;
- (3) the Director's Questionnaire (Long or Short); and
- (4) a consent form (if required at your site).

3. When It Is Not Possible to Do the Child-Care Assessment

When you are unable to visit the child-care facility, you need to conduct a separate telephone interview to obtain crucial information about the target child's child-care arrangement. This interview will ideally occur with the center director, but may occur with the mother, if the director refuses.

The "Director (or Mother) Telephone Interview for Centers We Cannot Visit" is used if either the mother does not want us to observe in the center or the center policy does not allow us to observe. It is used instead of the regular Director Telephone Interview, the regular Director Questionnaire, and the Child-care Observation. If the director refuses to be interviewed, use the "Director (or Mother) Telephone Interview for Centers We Cannot Visit" with the mother. If the mother is the respondent and she does not know the answer to any of the questions, ask her to find out and tell her you will call back later. (You can send her a copy of the questions to help her remember what to ask.)

A validity check will be performed on these interviews, by having a subset of study sites conduct the interviews with directors/mothers on whom we also conduct child-care assessments.

4. Materials Required for Child Care Assessment

The materials required for a child care assessment vary, depending upon whether the provider is a center-based provider, a family day care home-based provider, a babysitter, or a relative.

The child care visit checklist will help you determine which materials to bring to which type of visit. You may want to keep these worksheets on file at your site in order to have a record of when materials were submitted to your PC.

5. Confirmation Phone Call to Director

On the day of the scheduled appointment, call the director or caregiver to make sure the child and the child's primary caregiver are present. If they are not, find out from the director/caregiver how long the child or the primary caregiver will be away and reschedule your visit. If the primary caretaker is not present a number of times and/or if the child's 2-week window is almost up, observe the child without the primary caregiver. We will know from the ORCE caregiver ID numbers whether the primary caregiver was observed. Make sure that the center director will have completed the Director's Questionnaire before your visit. Answer any questions he/she has about the questionnaire or the visit. Make sure that the director has informed the staff in the child's room of your visit and that he/she or someone else in authority will be there to sign the consent form for the director when you come. If he/she will not be there, make sure that it will be OK for someone else on the staff to sign for him/her. Ask her to have the classroom caregiver call you directly if she has any questions about your visit, and then be available to take the call.

6. Obtaining Consent

Consent should be obtained from the director and from individual caregivers as well, after you arrive at the site and before you begin your observations.

In some cases, caregivers may be less than 18 years old. It is very important that you include these caregivers in the child care assessments. Sometimes, the child's only caregiver will be under 18 years of age. Other times, the child will have multiple caregivers, one of whom is under 18 years of age.

This poses a question for the consent forms. You should clarify procedures with your human subjects committee. In some cases, it may be necessary to obtain the consent of the caregiver's parent. Perhaps this consent can be obtained over the telephone. Perhaps it is required only if the under age caregiver is not being supervised by an older caregiver. You will need to get answers to these questions for your site.

7. Center Payment

Each participating center will be paid \$40 at the end of the second visit. (Some sites may wish to assure that all questionnaires are completed prior to payment.) For centers you will need to ask the director how he/she wishes to handle the payment. Some may wish to divide the payment equally among all participants; others may wish to purchase a gift for the center. Please be as flexible as you can.

C. Home Recruitment

1. Contacting the Provider

Contact the primary child-care provider by phone as soon as possible after getting information about the child's care arrangement from the mother or after the mother's contact with the provider. If your site prefers to send the literature to the child-care provider and then make the phone call, that is allowable. But be aware of the window for the child care assessments (15 months plus or minus one month). In the phone call, briefly explain the study, summarize what is involved on the provider's part, answer any questions, and obtain an initial verbal consent. If you cannot reach the provider by phone, send the RECRUITMENT LETTER AND STUDY DESCRIPTION and follow up with another call or ask the mother to have the provider call us.

If the provider says "no" at this point, try to find out why. You may be able to assuage his/her concerns. Ask if you might send the materials (RECRUITMENT LETTER AND STUDY DESCRIPTION) and call him/her back. If the provider is adamant, we cannot force ourselves upon him/her. We will then have to use the mother as our sole informant about the child's care arrangement (see below).

In addition, in cases of refusal, if the child has a secondary arrangement in which he/she is enrolled for at least 10 hours a week, call the mother back and ask if we can repeat the recruitment process for this provider.

Following is a list of "talking points" for Child-care Recruitment. Adapt these points as necessary for homes you have already visited.

1. Explain the overall purpose of the study, using the consent form as a guide. For example: children are growing up under very different circumstances today; child care has become a very important part of most children's lives; we need to understand how this affects children's development; etc. Note national significance, importance to children, families, and providers.
2. Describe the visit from the provider's perspective:
 - a. Two days of visits;
 - b. About 3 hours each;
 - c. Prefer mornings, if target child is typically awake then;
 - d. Most of the time will be spent observing the target child. THIS DOES NOT REQUIRE ANY CHANGES IN YOUR TYPICAL ACTIVITIES. In fact, we don't want anything unusual to happen;
 - e. We will be observing the environment in which the child spends his/her time; and
 - f. We will conduct an interview with you (about 30 minutes).
3. All procedures will be maximally convenient for the provider (we can be flexible).

4. All data are confidential. (Nothing is reported to any licensing agency; our purpose is research, not evaluation.) The only thing we would need to report is child abuse.
5. We will be paying \$40 for his/her/their participation. (In cases of multiple providers, find out how they would like this to work, e.g., divide among providers, program gift, etc.)

The following is a sample telephone script, for family day care, that includes the points mentioned above.

Script for Caregiver Phone Call (Family Day Care)

"Hi. My name is _____. I am on the staff of the NICHD Study of Early Child Care. You may remember that we visited you before... CHILD whom you care for has been part of our study since birth. IF SENT INFORMATION AHEAD OF TIME, I sent you a letter last week describing the study. Did you receive it?

IF THE CAREGIVER DID NOT RECEIVE THE INFORMATION, THEN DESCRIBE THE STUDY. The study seeks to learn how different people and places affect children's development. Because child care is such an important part of many children's lives, we want to observe children in their child-care setting. Children in the study are visited in their homes and child-care settings when they are 6, 15, 24, and 36

6
months old. I would like to come to observe CHILD when he/she is in your care when he/she is about 15 months old.

Let me give you an overview of what I would like to do. When CHILD is about 15 months old, I would like to visit you for a couple of mornings. The first morning I would spend most of my time watching what the child does when he/she is in your care. This would not require any changes in your typical activities. The second day I would also talk to you at the end of my visit for about 30-45 minutes about your background experience and about how you handle child care. At the end of the first visit I would leave you some brief questionnaires for you to complete when you are able. I would pick them up at the second visit.

Of course, everything is confidential. We are not part of any licensing agency.

In appreciation for your participation in this project, we would like to give you \$40.

Is it okay if I come?

IF YES, Great! I need to come at a time when CHILD will be awake for at least two hours. I would prefer to come in the mornings, if possible.

SCHEDULE VISIT IF POSSIBLE.

IF NO, Would you like for me to send you additional information about the study? SEE TROUBLE SHOOTING SECTION.

I will be sending you a consent form for you to look over and also a letter confirming the visit dates and times.

Thank you for your time.

2. Scheduling the Visit

If the provider says "yes", schedule a visit, using the following questions:

(1) "In your opinion, considering your schedule and CHILD's, what would be the best time for us to schedule a visit? I need to see CHILD when he/she is most likely to be awake for at least two hours and not likely to be interrupted by someone coming to visit (for example, the mother coming to feed him/her). I will need to make two visits of about 3 hours each."

The child is most likely to be awake and available in the morning, so if you have a choice, please schedule the

visit so that it occurs predominantly during the morning hours. Of course, some children will not be in child care at all during the morning.

(2). What day of the week is best for you? Do not observe children until they have been in an arrangement for at least 2 weeks. Aim for as close to the child's 15-month birthday as possible, give or take 1 month. It is extremely important that the child-care visit be scheduled within this 2-month window. Between 16 months 0 days and 19 months 0 days, 15 month visits may be conducted, but flagged as exceptions. After 19 months 0 days, a 15-month child-care visit is not conducted.

You should aim for the second child-care visit to be within 2 weeks of the first child-care visit and preferably within one week. The first child-care visit should be within 1 month of the home visit, if possible; preferably within 2 weeks. Schedule the visit at a time that the child's REGULAR caregiver(s) will be there (no substitutes). If regular caregiver is absent for one visit, it will have to be rescheduled.

(3) Select times and dates for the two visits, and include this information in the confirmation letter to the provider.

Thank the provider for being a part of the study and tell him/her that:

(1) You will call back the day of the observation appointment to confirm the appointment and make sure the target child is there;

(2) Before your visit, the provider should receive a letter confirming the visits and a description of the Study and the visits. Tell the provider that he/she can post this description for parents to see, if he/she wishes;

(3) If your site requires that a consent form be sent in advance, tell him/her that this will also be included with the letter.

You will then send:

- (1) the confirmation letter;
- (2) the description of the Study and visits;
- (3) a consent form (if required at your site).

3. When it is Not Possible to Do the Child-Care Assessment

When you are unable to visit the child-care facility, you need to conduct a separate telephone interview to obtain crucial information about the target child's child-care arrangement. If the mother will not allow us to visit the provider in a home-care arrangement or if the home caregiver refuses to be visited, the "Telephone Interview about Child Care for Home Arrangements We Cannot Visit" is completed. Conduct this interview with the provider, if possible. If not, conduct the interview with the mother. If the mother is the respondent and she does not know the answer to any of the questions, ask her to find out. You can send her the questions to help her remember what to ask.

A validity check will be performed on these interviews, by having a subset of study sites conduct the interviews with mothers on whom we also conduct child-care assessments.

4. Materials Required for Child Care Assessment

The materials required for a child care assessment vary, depending upon whether the provider is a center-based provider, a family day care home-based provider, a babysitter, or a relative.

The child care visit checklist will help you determine which materials to bring to which type of visit. You may want to keep these worksheets on file at your site in order to have a record of when materials were submitted to your PC.

5. Confirmation Phone Call to Provider

The day of the scheduled appointment, call the provider and confirm that the date for the observation is still okay and that the child is there. Answer any questions he/she has about the visit.

6. Obtaining Consent

Consent will be obtained from the provider and from any additional helpers/providers who are observed, after you arrive at the site and before you begin your observations. If caregivers (or their helpers) are under 18 years of age, check with your human subjects committee about consent procedures. You may need to get their parents' consent.

7. Provider Payment

The provider will be paid \$40 at the end of the second visit. (Some sites may wish to assure that all questionnaires are completed prior to payment.) For family day-care homes with more than one provider who has been involved, you will need to ask the owner how he/she wishes to handle the payment. Some owners may wish to divide the payment equally among all participants; others may wish to purchase a gift for the home. Please be as flexible as you can.

D. Problem Solving

1. Trouble Making Contact With Caregiver/Director.

The caregiver or the director of the center is not available when the project staff person calls. A person other than the caregiver (home daycare) or director (center daycare) answers the phone or a machine answers the phone. Use the following script:

"Hello. This is (your name) from the Study of Early Child Care. (Name of child) is in (name of provider's) care. (Name of child) and his/her mother are part of a study on early child experiences and development. (Name of mother) has agreed to participate in the study and has contacted caregiver/provider (or you) about the possibility of observing (name of child) while he/she is in (name of caregiver/director/your) care. Could (he/she) (you) please call me back today or tomorrow at the following number: "

If speaking to a person add:

"I am sure he/she is very busy so I hope it's okay for me to call (her/him) back if I don't hear from (her/him). Is there a good time when I might reach (her/him) today or tomorrow? Thank you. Bye."

Make the second phone call at the time suggested, or some time during the following day. If the caregiver/provider is still not available, leave another message asking that he/she get back to you within the day.

If the phone call is not returned after the second try (second day) and no reason is given for the caregiver/provider's unavailability, then follow up with a third call the following day (third day) to leave a third message.

If by the morning of the fourth day (at the latest), the caregiver/provider has not returned your call, and the mother has made the original contact, call the mother, asking her to approach the caregiver/provider again with the following message (we are asking the mother not to read this to the caregiver/provider, but to try to include the following points when speaking again with the caregiver/provider):

"The Study of Early Child Care that (name of child) and I are involved in would like to speak with you to discuss their study and your possible participation. They are having difficulty reaching you. I know you are very busy but they feel your input is very important to the study. Would you mind speaking with her/him within the next couple of days about the study and the possibility of a visit. Is there a good time for them to reach you to discuss the study and a possible visit?"

Alternatively, you could at this point send the RECRUITMENT letter and a note suggesting that the director call you at his/her convenience.

If the caregiver is still unresponsive, the project staff person could suggest that the mother ask the caregiver/provider

if he/she would like to be introduced to the project visitor before he/she agrees to participate.

2. During Contact With the Caregiver/Director, the Provider Says "No" or Is Ambivalent About Participation

Try to find out why. If the provider is adamant about refusing to discuss participation, we have a missing child-care observation. If the caregiver is willing to discuss refusal or is ambivalent about participation, use the following troubleshooting suggestions to encourage participation:

a. Discussing the study and its importance

Summarize what is on the Study Description, emphasizing its importance to children, its national significance, and the critical importance of caregiver/provider participation in the study. If he/she has received the description, ask if he/she had a chance to read the description and if there are any questions about the study or his/her participation. Mention that the caregiver/provider/center will receive a payment of \$40 at the end of the second visit in appreciation for their time and input.

- b. Provider/Director is concerned the visit would be too disruptive to normal routines.

Explain that:

- (1) The date and time of the visits are arranged for the convenience of the caregiver/director;
- (2) Our project staff person will be as non-intrusive as possible;
- (3) Our primary purpose is to observe the child in normal circumstances. We do not want any special arrangements made for the visit (changes in schedule, etc.);
- (4) We understand your primary responsibilities are to the children;
- (5) Although we do need to speak with you about your views and past experience, this brief interview can be at your convenience and you can request that we leave at any time, if you feel circumstances warrant it.

- c. The caregiver/director is concerned about the privacy of the staff and other children and parents.

Explain that:

- (1) All observations and staff comments are kept confidential and are shared only with project staff (with the exception of child abuse);

(2) Any information from the observations or interviews will not be shared with the parent (of course, overall study results will be made available to any interested caregiver/provider.);

(3) No information will be gathered on other children in their care;

(4) Any caregiver who is observed at a center is asked for consent prior to the observation.

- d. Caregiver/Director wants to think about it first or discuss it further with the staff before giving consent or scheduling a visit.

Ask for a specific time to call back to discuss their participation. If necessary, mention that we do have a time constraint in that we need to see the child as close as possible to his/her 15-month birthday. If all else fails, go back to the mother again and see if she can persuade the caregiver.

- e. The caregiver/director seems concerned that you may report your findings to licensing officials.

This is particularly pertinent to family daycare providers, some of whom are unlicensed and operating illegally. If you sense this is the source of a provider's hesitation, be explicit

about the fact that you will not report any data or anything else that you hear or observe to licensing officials. All data are confidential. (The only reporting requirement with which you must comply concerns suspected child abuse or neglect.)

3. The Provider Takes Steps That Create an Atypical Day.

Providers may try to schedule your visits when other children are asleep, when some children are absent, or after a "problem child" has gone home. This may be a real problem in smaller, informal arrangements. If you get a sense that this is happening when you schedule or confirm the visits on the phone, you should reiterate the importance of seeing a typical day and address his/her concerns about being "tested" or about the disruptiveness of the visit.

More often, you will sense that the visit is atypical when you arrive to conduct your observation. There is little you can do at this point, unless you are willing to reschedule the visit (with no guarantee that the rescheduled visit will be more typical). In cases where the children are asleep at non-nap times and you sense that this has been done to accommodate your visit, try to wait until they wake up. There is a place on the End-Of-Visit form to indicate whether you felt you have captured a typical day. Indicate "no" in these cases.

4. Information About Care From the Caregiver Contradicts Information From Mother.

If the information from the caregiver contradicts the information from the mother, call the mother back to clarify. If necessary, complete a new 13-month phone call (if you learn that the child-care situation has changed), and send a note to the Data Center telling them to ignore the earlier 13-month phone call data.

III. ASSESSMENT PROCEDURES

A. General Procedures

This section covers general considerations for the child-care visits, including the determining of when the visit should take place, the order in which to collect the data, determining which caregiver(s) to observe in the case of multiple caregivers, and procedures to follow in the case of a single arrangement being used by more than one Study child.

1. Number of Visits

All data collection should occur within two visits, unless there are circumstances that prevent the collection of the minimum required data in two visits and a third visit is necessary. Do everything you can to fit the required data collection into two visits. Do not pressure caregivers to

complete their interviews or to let you stay longer when it is obvious that your presence is not wanted.

2. Timing of Visits

The windows for the 15-month visits are as follows:

	15 Month Visit
Schedule between	14 months, 0 days to <16 months, 0 days
Exception period	16 months, 0 days to <19 months, 0 days
No data after	19 months, 0 days

All data collected during the exception period must have the written approval of a principal investigator. Because of the danger of cancellations all visits should be scheduled as early in the window as possible.

Other scheduling constraints for the child-care visits are:

- ♦ First child-care visit should be within 1 month of the home visit, and preferably within 2 weeks.
- ♦ Second child-care visit should be within 2 weeks of the first visit, and preferably 1 week later.
- ♦ Do not schedule any visits before the target child has been enrolled in the arrangement for at least two weeks.

- ♦ If the child-care visits cannot be scheduled within the 2- and 3-week window, then exceptions must be noted.

The scheduling of the visits should be worked out with the child-care provider when the appointment is made. You want times when the child is as alert as possible, and preferably in the morning.

3. Confirming the Visit

Call the director/provider on the day of the visit to confirm the appointment and ascertain that the child is present. If you arrive and you discover that the child will not be there, reschedule the visit, trying, insofar as possible, to stay in the window. DO NOT COLLECT ANY DATA if the target child is not there. As described below, the child-caregiver observations must be spread across 2 days; thus, if you collect data (e.g., caregiver interviews) on a day when the child is sick, this would put you in the position of visiting on 3 days, which should be avoided.

4. Number of Observers

Only one research assistant (RA) will visit each child-care facility, unless a second individual must accompany the RA for safety reasons or for a "live" reliability check. The observer can not be the person who was/will be the child's home visitor at 6 or 15 months. Child-care and home visits must be independent.

We strongly recommend that the same RA conduct both visits for a given child-care arrangement and if possible both 6 month and 15 month child care assessments.

5. What to Bring

You should bring with you to the child-care visit the following:

- a. Two additional copies of the consent form -- one to leave and one to bring back signed;
- b. A copy of the parents' signed consent form in case the provider wants to see it;
- c. Multiple copies of all data forms. Remember to take to the second visit: (1) extra copies of the questionnaires, in case caregivers have lost the ones you gave them at the first visit or in case the caregiver(s) you gave them to at the first visit are absent on your second visit; and (2) another set of consent forms in case there are new caregivers;
- d. The Director's Telephone Interview (filled out); (for centers only)
- e. Clipboard, "observe-record" tape or timer (use the 6-month tape), several #2 pencils;
- f. Stamped return envelope for caregiver to use in sending back any questionnaires not completed by the second visit; and
- g. Child-care ID Worksheet.

6. Arriving at the Center/Home and Getting Started

In a center, find your way to the Director's office. Chat with him/her about your visit. Get the Director's Questionnaire (Form 11D) or the Short Form of Director's Questionnaire (Form 11U) (as appropriate) which he/she should have completed. If he/she has not, suggest that perhaps she could fill it out before you leave or go over it with him/her on the spot. If he/she has questions about the questionnaire, answer them. Check that the questionnaire is complete. Ask him/her to describe all of the caregivers who are likely to be observed interacting with the target child and record this information on the Child-care ID Worksheet. Be sure to ask about each one's relationship to the child and whether he/she is specifically assigned to the child. Ask the Director to take you or show you to the room where you will be observing the target child. When you meet the caregivers, make sure you have completed permission forms for each caregiver who will be in the room with the child.

7. Whom to Observe, Interview, and Ask to Complete Questionnaires

In many cases, the child will have only one caregiver. However, in some large family day care homes (group homes) and in centers, the child may be cared for by more than one caregiver. In these cases, you need to determine whom to observe.

Observations will be done noting which caregivers and other adults were in the room and which caregivers and adults interacted with the child during each observation interval. All the caregivers with whom the child interacts, including non-staff adults and helpers under 18 years, will be observed during the Behavior Scales observations. Because the focus is on the child's total caregiving experience, we will note which caregiver interacted during an observation period, so we can link up the behavior of individual caregivers with their individual interview data.

The Qualitative Ratings will be completed for up to 3 caregivers with whom the child interacts for at least two of the four 10 minute segments in a 44-minute observation.

Up to a maximum of two of these same caregivers will be interviewed. All caregivers who are interviewed should be asked to fill out questionnaires as well. The two caregivers who are interviewed should be the following:

First, the caregiver who interacted with target child most during the two sets of observations conducted on Day 1. It is important to identify the caregiver who interacted the most with the target child, who may or may not be the caregiver who was in the toddler room the most. In centers that assign specific caregivers to specific children, you might expect that it will be this caregiver, but again, it may not necessarily be this caregiver.

Second, the "lead" teacher in the class, if he/she interacted with the target child at all during the observation.

Third, if there is no "lead" teacher, the caregiver who interacted with the child second most during the observations (if observed for at least 20 minutes and Qualitative Ratings were completed).

If the same (two) caregivers with whom you left the questionnaires at Visit 1 are not there to be interviewed at Visit 2 (a situation you should try to avoid), give the second day's caregivers the questionnaires, and interview them, as well.

Some family day care providers will have "helpers". These are often family members who do not work full-time in the home and many will not consider themselves to be caregivers. For our purposes, what is important is whether they provide care to the target child 10 or more hours per week, on a typical week. In this case, they are caregivers to us. They need an ID number. The primary caregiver should get a REL code of 4 (since this really is a hierarchical arrangement -- it is clear who is in charge and who is primarily responsible), and the "helper" should get a REL code of 5.

These "helpers" who meet our 10 hours a week criteria should also get the questionnaires and interviews if at all possible. And, their IDs should be indicated on the ORCE when they are observed.

8. When Dad is the Care Provider (and Other Family Exceptions)

When the father is the care provider, the visit follows the same procedure as other home care visits, except that: (1) you use the Father Interview form; (2) you DO NOT give any father the "Taking Care of Young Children" Questionnaire or the "Parent-child Behaviors when Parent Leaves/Returns" ("Pick up/drop off") Questionnaires; (3) you do not give HHS fathers the "Ideas About Raising Children" Questionnaire; (4) you do not complete the items on the Profile that are not applicable for care arrangements with only the target child (and sibs).

When care is provided in the child's own home by a sitter, follow the same procedure as for daycare homes. When the target child alone or the target child and his/her sibs are the only children, follow the instruction on the Profile to drop the Individualizing section.

When care is provided in the child's own home by the mother and the mother is a child care provider, providing care for other, non-resident children at least 10 hours a week, use the HOME INTERVIEW FOR MOTHERS WHO ARE CHILD CARE PROVIDERS; do not give the questionnaires ("Taking Care of Young Children," pick up and drop off, and "Ideas about Raising Children"); do not administer the HOME.

9. Assigning Child-care ID's.

Each child-care provider and center director (whether observed or not) should be assigned an identification number. This ID consists of 7 digits and is tied to both the research site and the relationship (REL) code. By the 15-month observation, many programs and providers will have already been observed previously at 6 months. Before the visit, child-care observers should check the master list to determine if any arrangement ID has already been assigned.

A general picture of the seven-digit code is:

Digit	Represents
1	Site
2	Relationship to Child
3	Assignment Code
4-7	Unique Provider Code.

The details for coding each component of the provider/director ID follow.

The first digit of each Provider and Director ID is the Site Code. The second digit is the Relationship Code. This code identifies the person responding to the interview/questionnaire or who was observed, and refers to the relationship of the respondent to the study child. Specifically REL should be coded as follows:

0 - Mother (in cases where the mother is a child-care provider and also takes care of the target -- her own -- child).

1 - Father (The father is the child-care provider.)

2 - Grandparent (The grandparent is the child-care provider.)

3 - Other Relative (Another relative, including sibling, or the mother's lesbian partner is the child-care provider.)

4 - Primary Child-Care Provider (This provider has supervisory responsibility for the target child's classroom; sometimes called a head or lead teacher. Use this code, as well, for the owners of large family day-care homes, sometimes called group homes, in which more than one caregiver is employed or when the care provider's husband, mother, sister, or anyone else regularly provides care for target child more than 10 hours per week. All of these other providers are assigned a REL code of 5.)

5 - Support Child-Care Provider (This is a provider who also takes care of the target child but who is not the teacher-in-charge for the target child's classroom, sometimes called an assistant teacher or aide, or who is not the main child-care provider in a home, sometimes called a helper.)

6 - Child-Care Provider (No hierarchical designation; use in instances where all classroom teachers are of equal status, e.g., all "teachers" or all "assistant teachers." This is also to be used in all instances where there is only one provider, e.g., in a small family day care home or in-home arrangement, given that this provider is not the mother or another relative.)

7 - Director (only in centers)

As you can see, if the child-care provider is related to the child, use the relative code. If the child-care provider is not related to the child, use code 4, 5, 6, or 7. If the child has more than one provider who fits a single relationship code (e.g., two assistant teachers), assign both of them the same REL code. What makes the ID unique is the last four digits, as described in the next paragraph.

The third digit, the Assignment Code, indicates whether the provider is specifically assigned to the Target Child:

- 1 = The provider is specifically assigned to the target child;
- 2 = The provider is not specifically assigned to the target child;
- 3 = Only one provider (use in arrangement, such as father care or family day-care home with no other available providers).

Don't take the director's word about assignment, ask the provider.

The remaining digits in the Child-Care Provider ID (4 through 7) are the unique code for each provider, starting with 0001 and ending with 9999. Thus, the first assistant teacher who is observed/interviewed at the University of Virginia site would be assigned ID 6520001. The second assistant teacher, if applicable, would be assigned 6520002. This unique ID will be assigned after the second child-care visit by the site coordinator in consultation with the child-care data collector. Make sure that this final ID is written on ALL FORMS in the designated spaces.

The Director ID will serve as the Child-care ID number for center-based arrangements and the caregiver ID number will serve as the Child-care ID number for all other arrangements. In the case of large family day-care homes with more than one provider, the ID of the lead child-care provider will serve as the Child-care ID. If a family or group home is co-owned and there is not a clear primary provider, randomly choose the ID of one of the providers as the arrangement ID. In cases where the same provider and/or center is visited at least twice because 2 study children use the same arrangement, or because a child was in the same care arrangement at 6 months, use the same ID for both observations. This is our only way of knowing that it is the same center/provider. The Site Coordinator will keep a

confidential list that matches names and ID's (see Appendix I: Confidential Worksheet for Assigning Final Child Care IDs).

If the center remains the same over 2 assessment points, but the director changes, note on the Director Change Form (DM-J), that the director has changed for this center and the date of the change (if known). The data center will then deal with this situation. If a provider has moved from one program to another, then that provider should keep the same final caregiver ID number.

During the visit, the provider IDs will be temporary (see below) and then finalized by the site coordinator or her designee after both visits to a given arrangement are completed. This will occur for visits to center-based and large family day care (often called "group homes") arrangements, in which multiple caregivers are observed, interviewed, and asked to complete questionnaires. Recall that, although a maximum of two caregivers are interviewed and asked to complete questionnaires, more than two caregivers may be observed, since this observation is child-focused.

The "on-site" temporary ID's will be assigned using an ID worksheet (see below and Appendix H), and then finalized by the

SUMMARY

ASSIGNING Child-care IDS

The identification number consists of 7 numbers and is tied to both the research site and the relationship (REL) code.

SITE CODE (First Digit)

REL CODE (Second Digit)

- 0 - Mother
- 1 - Father
- 2 - Grandparent
- 3 - Other relative
- 4 - Primary child-care provider
- 5 - Support child-care provider
- 6 - Child-care provider
- 7 - Director (only in centers)

ASSIGNMENT CODE (Third Digit)

- 1 - Specifically assigned to target child
- 2 - Not specifically assigned to target child
- 3 - Only one caregiver

UNIQUE CAREGIVER ID (4-7th Digits)

0001 - 9999

site coordinator (or counterpart) after the second visit to the arrangement. BRING THE ID WORKSHEET TO THE Child-care VISIT. Prior to assigning the final IDs, the site coordinator (or counterpart) should check the master list of provider names to determine if the provider or the arrangement has already been assigned a permanent ID. If the provider had been assigned an ID on an earlier visit (at 6 months or with another child) then the following procedure should be used:

1. The last 4 numbers of the ID always stay the same for a provider. This is the provider's unique ID.
2. The first number of the ID is the site code and will never change.
3. The second and third digits will change if the caregiver's position has changed.

Keeping track of caregivers' final IDs as caregivers and children change programs is a formidable task. Sites may either maintain a file on each caregiver seen or they may keep a master list of caregivers including the same information that is contained in the files. If files on each caregiver are maintained, they should be labeled and alphabetized by caregiver name. The file should include the caregiver's name, unique ID # (the last 4 digits), place of care, address and phone number of place of care, and any other information necessary for contacting the caregiver. The file should be updated if the caregiver changes her place of care. The file should also contain a list

of all study children who are in the caregiver's care. This list can be added to as subjects are added.

10. Using the Child-care ID Worksheet

Assigning child-care provider IDs and keeping them straight across observations will pose a major challenge in child-care centers, where the target child is likely to have multiple caretakers. The CHILDCARE ID WORKSHEET (see Appendix H) is designed to facilitate this process and assure our ability to cross-walk from the observational data to the questionnaire and interview data.

AFTER FINAL IDs ARE ASSIGNED AND WRITTEN ON THE CHILDCARE ID WORKSHEET, TRANSFER THESE IDS TO THE LAST PAGE OF THE ORCE BOOKLET, CAREGIVER IDS FOR ORCE SESSION. BE SURE TO STORE THE CHILDCARE ID WORKSHEET IN A SECURE AREA IN THE SITE FILES.

As suggested in the previous section, it is CRUCIAL that the RAs assign temporary caregiver ID numbers when they visit the center, given the high turnover rates among staff. Immediately prior to starting the observation, find out who is likely to be in the classroom and interacting with the target child (ask the lead teacher or director) . Assign each of these individuals a temporary ID number using the ID worksheet (see Appendix H). Of course, you may be told that only one caregiver will be seen, only to find that a second caregiver enters the classroom and interacts with the child. Assign this individual a temporary ID

for "Caregiver 2" and when your observation is completed, check on this caregiver's relationship to the child and fill this information in on the worksheet.

For each observation cycle, match your temporary ID to the actual caregivers that you observe. For example, if you observed 4 different caregivers during Cycle One (1=A (Sally), 2=B (Jenny), 3=C (Feehah), and 4=D (Don)), then you observed 3 of them during Cycle Two (say A, B, & D) PLUS one new caregiver, you would record the following for Cycle Two: 1=A, 2=B, 3=E, 4=D. This will allow us to match Caregiver 1 to Caregiver 1, Caregiver 2 to Caregiver 2, and Caregiver 4 to Caregiver 4 across these 2 cycles. We will also know that Caregiver 3 in Cycle One is not the same person as Caregiver 3 in Cycle Two. Use the space for "Description" to record permanent cues to help you keep the caregivers straight, e.g. hair, size, first name, etc. Clothes are not good cues since they will likely change from Visit 1 to Visit 2.

After observing for the Behavior Scales, you will record data for the qualitative ratings for no more than 3 caregivers. This is described in Section III.E.5, Guidelines for the Qualitative Scales. For the purposes of the worksheet, indicate, for each caregiver (1 through 8), whether you consider him/her in the qualitative ratings, and which Caregiver Number (1st, 2nd, third) he/she was given on the qualitative ratings.

At the end of each day, you will complete the End-of-visit (Global) Ratings for up to 3 caregivers. Indicate on the worksheet using Cg1, 2, 3....8, which caregivers you rated, and which day it is (1 or 2). For example, Caregiver 1 for the end-of-visit ratings may be Caregiver 1 (=A) from the Behavior Scales, or it may be another caregiver. We need to match up these data, and so we need you to match actual individuals on this worksheet.

Finally, we need to know which caregivers completed the questionnaires and the interviews. Remember that all caregivers who do the interviews also complete the questionnaires (maximum of 2). Put their temporary ID on the questionnaires themselves and then replace them with the final ID once you are back in your lab. Also, indicate on the worksheet which caregivers were given the questionnaires.

Finally, before you leave the center on the last day, make sure that you have assigned a REL and ASSIGNMENT code to each caregiver. This may require speaking to the caregiver; e.g., "Are you specifically assigned to the target child?" Without this information, your site coordinator cannot assign a final ID.

Here is an example of a completed CHILDCARE ID WORKSHEET, using 2 observational cycles:

Observation Cycle #1

Behavi	orals	TempID	FinalID	Desc	REL	ASSIGN	QUALS?	END-VISIT?	INT/QUES?
Caregiver 1	A			short red hair	4	2	Cg1	Cg1-Day1	yes
Caregiver 2	B			curly black hair	5	1	Cg2	Cg2-Day1	yes
Caregiver 3	C			male, blond hair	5	2	Cg3		
Caregiver 4	D			long red hair	5	2		Cg3-Day1	
Caregiver 5									

Caregiver 6
Caregiver 7
Caregiver 8

Observational Cycle #2

Behaviorals	TempID	FinalID	Desc	REL	ASSIGN	QUALS?	END-VISIT?	INT/QUES?
Caregiver 1	A		short red hair	4	2	Cg1		
Caregiver 2	B		curly black hair	5	1	Cg2		
Caregiver 3	E		Dark black glasses	5	2			
Caregiver 4	D		long red hair	5	2	Cg4		
Caregiver 5								
Caregiver 6								
Caregiver 7								
Caregiver 8								

We now know that the Qualitative Ratings for Cycle 1 considered caregivers A, B, and C and that the Qualitative Ratings for Cycle 2 considered Caregivers A, B, and D. We know that at the end of Day 1, the End-of-Visit Ratings were completed for caregivers A, B, and D (in that order) and we know that caregivers A and B were given the questionnaires to complete. The actual questionnaires should have been marked with "A" and "B" before they were given to these two individuals.

After all the data are collected, the Site Coordinator or her designee should take this information, assign final IDs, and use the final IDs to complete all of the SCANTRON face sheets for the ORCE, interviews, and questionnaires. Also, put the final IDs and names on the CONFIDENTIAL WORKSHEET (see Appendix I) for assigning final IDs. DO NOT send the CONFIDENTIAL WORKSHEET used in assigning final IDs to the Data Center.

11. When to Use Center vs. Home Instruments

If an arrangement uses space that doubles as a residential home, then use the home assessment instruments and procedures. This will apply to most so-called group family day care homes, which often employ more than one caregiver and enroll 6-12 children, but operate in residential settings.

12. Data Collection Procedures

At the first visit, the emphasis will be on observation. Caregivers will not be interviewed at the first visit, because having information about the caregiver's background, training, etc. might bias observation of her behavior. Caregivers will be interviewed on Day 2 only, after all the required observations have been completed. You will need to be somewhat flexible, given special circumstances that will undoubtedly arise. You may suggest that the target child's nap time is a good time for the interview, but he/she may see things differently. EMPHASIZE that you need to complete the interview before you leave and try to establish at the beginning of your visit the optimal time to do it. Sometimes it may work out better to interview the caregiver before you have finished all required observation cycles -- because the child falls asleep, the caregiver has a break, etc. If you have to make a choice between interviewing the caregiver before the 4th (or even the 3rd) observation cycle and coming back to interview her at a third visit, do the interview before the observations. Just be

aware that you should not be influenced in your observation ratings by any information about the caregiver's background that you have discovered in the interview. Caregiver training is not a guarantee of greater sensitivity, for example.

A summary of the suggested order of the observation and interview procedures is as follows:

FOR CENTERS

First visit

Introductions, instructions, getting settled (10 minutes)

First 44-minute observation cycle: 30 minutes on Behavior

Scales and 14 minutes on Qualitative Ratings

5-minute break (if necessary)

Second 44-minute observation cycle

5-minute break (if necessary)

Third 44-minute observation cycle (if desired and appropriate)

Profile observation (40 minutes)

"Typical visit" questions (3 minutes)

Questionnaires -- leave to pick up at second visit

End-of-visit rating scales for first visit (2 minutes)

Second visit

Third or fourth 44-minute observation cycle (DO NOT
COMPLETE ALL OBSERVATIONS ON DAY 1; at least one MUST
be done on Day 2.)

5-minute break (if necessary)

Fourth or fifth 44-minute observation cycle (if needed or
desired)

5-minute break (if necessary)

Interview with up to 2 caregivers including:

"Typical visit" questions (3 minutes)

Profile interview (10 minutes)

Background interview (15 minutes)

Pick up questionnaires

End-of-visit rating scales for second visit (2 minutes)

FOR HOMES

First visit

Introductions, instructions, getting settled (10 minutes)

First 44-minute observation cycle: 30 minutes on Behavior

Scales and 14 minutes on Qualitative Ratings

5-minute break (if necessary)

Second 44-minute observation cycle

5-minute break (if necessary)

Third 44-minute observation cycle (if desired and
appropriate)

Profile observation (40 minutes)

"Typical visit" questions (3 minutes)

Caregiver Questionnaires -- leave to pick up at second
visit

End-of-visit rating scales for first visit (2 minutes)

Second visit

Third or fourth 44-minute observation cycle (DO NOT
COMPLETE ALL OBSERVATIONS ON DAY 1; at least one MUST
be done on Day 2.)

5-minute break (if necessary)

Fourth or fifth 44-minute observation cycle (if needed or
desired)

5-minute break (if necessary)

Interview with up to 2 caregivers including:

"Typical visit" questions (3 minutes)

Child-care HOME interview (20 minutes)

Profile interview (10 minutes)

Background interview (15 minutes)

HOME completed (5 minutes)

Pick up questionnaires

End-of-Visit rating scales for second visit (2 minutes)

13. Minimum Data Collection Required

At least two visits and four observation cycles are required. A cycle is 30 minutes on the Behavioral Scales (15 of actual observing and 15 of recording) + 14 minutes on the Qualitative Scales. The minimum length of a cycle will be 20 minutes, although the 20 minutes will be spent doing the Behavioral Scales, the ratings for the Qualitative Ratings will be based on this time as well. DO NOT COMPLETE ALL OF THE OBSERVATION CYCLES ON A SINGLE DAY. At least one of them must occur on Day 2.

Interrupted Cycle

If you must interrupt an observation cycle for some reason (for example, the child falls asleep) you may resume coding where you left off IF THE CAST OF CHARACTERS PRESENT HAS NOT CHANGED. If, however, there have been any changes in the setting or the people present, you will need to start a new (replacement) cycle. Mail both completed and incomplete cycles to the Data Center.

14. Feedback

If the caregiver asks for feedback, assure him/her that he/she will be sent a copy of the results when the Study is completed and that, due to confidentiality, we cannot release any information about individual children, families, or child-care programs.

Only general information should be given to caregivers. Emphasis should be on our wish to capture the child's experience

in the setting and not on any desire to evaluate the quality or adequacy of the center, home, or caregiver. Emphasis should be on the "exploratory" (vs. evaluative) nature of the data collection: We don't know how children's experiences contribute to their development unless and until we collect information about those experiences.

If the parent asks for information about the child-care setting, most times the person talking to the parents will not have any information about the child-care setting because a different observer will be making these visits. Parents who ask, however, should be encouraged to observe in their own daycare sites, to talk to their caregivers about their concerns, etc. They should also be told that decisions about day care arrangements are personal ones, and that what makes one parent comfortable will not necessarily make another parent happy; hence our advice is not as important as the parents' personal observations and values.

15. Flexibility

Child-care environments are rarely consistent or predictable. This requires flexibility on the part of the research assistants. It is important that -- within the constraints of the prescribed order of observation/interview procedures -- you accommodate to the caregiver's (program's) needs and schedule, in addition to the child's schedule.

16. Multiple Study Children in Same Arrangement

In those cases in which one study child attends the same child-care arrangement as another study child, the following procedures should be followed for the 15-month observations:

1. It is desirable to have different child-care observers collect the data for the children.

2. A complete set of caregiver-child interaction (ORCE) data should be collected for all children; i.e., four 44-minute ORCE observations should be made for all Study children.

3. Long forms of the caregiver interviews Form 11F), the PROFILE Form 11R or 11S), and the Child-care HOME (Form 11J) do not need to be completed unless there has been staff turnover in the target child's classroom. If more than two months have elapsed since the first child's observations, the SHORT FORM OF THE DIRECTOR QUESTIONNAIRE (Form 11U) should be given to the Director. If less than two months have elapsed, the director does not need to complete the DIRECTOR QUESTIONNAIRE (Form 11D). Providers should complete the questionnaires, WHEN PARENT LEAVES/RETURNS and TAKING CARE OF YOUNG CHILDREN (both found in packet 11K) for each child in the study. IDEAS ABOUT RAISING CHILDREN (Packet 11K) needs to be completed only once per caregiver at 15 months.

17. Taking Leave

Before you leave, say goodbye and thank the caregivers and Director and reconfirm the next visit. Pick up the Director's Questionnaire, if you haven't already. At the second visit, pick up the caregiver's questionnaires.

B. General Interview Procedures for Caregivers

This section describes the procedure for obtaining the interview data from the caregiver(s).

At the end of the second visit, you will interview the caregiver(s) -- maximum of 2 -- to obtain background information, such as their education and experience. Caregiver interviews should be done after the observations, at the caregiver's convenience. You may suggest that the target child's nap time is a good time for the interview, but he/she may see things differently. EMPHASIZE that you need to complete the interview before you leave.

Reread the section on assigning caregiver IDs (see Section III.A.9, Assigning Child-care IDs, above) and be sure to match the IDs used during the observations with the IDs of the caregivers who are interviewed.

The interview is structured predominantly as a "guided" interview. Read the question to the caregiver (he/she will ideally be sitting where he/she can read along with you, e.g. side-by-side at a table) and record his/her answer. In some

cases, there are several response choices. You should still record the answer(s), but in these cases, you do not need to read every response choice unless the caregiver wants you to. Rather, move the interview form in front of the caregiver and suggest that he/she read the responses and then indicate his/her answer(s) for you to mark.

The best circumstance under which to administer the interview is one in which the caregiver is not simultaneously responsible for supervising children. In most cases, however, this will be impossible. Thus, you will need to become accustomed to frequent interruptions. You will want to sit beside the caregiver so that he/she can read along with you. You (and he/she) will undoubtedly be tempted to simply let the caregiver complete the interview as a questionnaire. Our experience tells us that this produces both incomplete and unreliable data. Although most of the interview items are very straightforward, a busy caregiver will always be tempted to read and answer items quickly and, perhaps, not as carefully as possible. You will also find that there will be more questions than you might anticipate, given the individual circumstances that frequently arise (e.g., "I haven't had any training in the last 12 months, but I spent the previous year taking a college course in child development -- can't I count that?").

There are quite a few SKIP patterns in the interviews. Be sure to have these patterns well memorized, along with the

information in the manuals that accompany each interview form, so that the interview will go as smoothly as possible.

In administering the interview, please listen to what the caregiver says and remember it from one question to the next. If he/she has already (inadvertently) answered a question in responding to an earlier one, when you come to the later question pose it in a confirmatory way ("And you said that..."), not as if you hadn't heard her the first time. Ditto if you see her doing something; don't act as if you didn't notice. Say "And I noticed... do you always/ do you usually" -- or whatever is appropriate. Use common sense, tact; be sensitive, intelligent. Also, please use language that is appropriate for the individual caregiver: if he/she considers herself a "babysitter," don't refer to her as a "caregiver" or "care provider"; if the father is not married to the child's mother don't refer to her as "your wife," and so on.

There are multiple versions of the interview to suit the full range of child-care arrangements that we are likely to observe:

1. Center Version (LONG FORM) (Form 11F) -- Use for caregivers, including mothers, in center-based care who have not been interviewed before.

2. Center Version (SHORT FORM) (Form 11E) -- Use for caregivers in center-based care who have been interviewed before. Before you go to the center, review the responses the

director/caregivers gave on the prior interviews so you will know what the earlier situation was (re caregiver training, class size, etc.)

3. Home Version (LONG FORM) (Form 11J) -- Use for all home-based caregivers, including family day-care providers, nannies, grandmothers, and paid or unpaid helpers (who provide regular care at least 10 hrs/week), who have not been interviewed before. Some of the questions on this form have to be stretched to be appropriate for a "helper." You must take into account the primary care provider's responses. Use the following guidelines for interviewing a helper:

Q A8, A9, A10, A11, A12: Think of the primary care provider as providing help to the helper

Q B4, B5, D1, D3, D5, D6: Use the primary care provider's response as to rates, numbers of children, (you can fill these in after the interview).

Q D2, D4, D8 - D17: Ask for the helper's opinion, relationship to children, preferences.

This form is also used in the situation where a mother brings her baby to work and someone looks after him/her (not in a work-site center).

4. Home Version (SHORT FORM) (Form 11I) -- Use for all home-based caregivers, who have been interviewed before. Before you go to the home, review the responses the caregiver gave on

the prior interview so you will know what the earlier situation was (re caregiver's training, etc.)

5. Home Version for Fathers(Form 11G) -- Use for all arrangements in which the father is the provider. If the father was not the child's caregiver at 6 months, use the LONG version (Form 11G); if the father was the caregiver and was interviewed at 6 months use the father SHORT Form (Form 11V).

6. Home Version for Mothers Who Are Child Care Providers (Form 11W) -- In general, it would be helpful at the outset of the interview to explain to mother that you are interested in her role as a child-care provider for other children as well as target child.

7. Differentiating Centers from Family Day Care Homes

With respect to group family day care homes, we will use the measures for home-based child care when the care occurs in space that is also used as a residential home. We will use the measures for center-based care when the care occurs in space that is not also used as a residential home (even if the building looks like a home). If there are two providers in the family day care home, collect all relevant data (observations, interviews, questionnaires) for both of them.

C. Interview Administration

1. Director Telephone Interview

This is a straightforward interview, which consists of 8 questions. If the director does not know the answer to any of the questions and cannot easily look it up while you are on the phone, ask her to look it up and fill it in on the questionnaire you will be sending her. Then enclose the unanswered question(s) with the Director Questionnaire.

2. Director Questionnaire

Be sure to explain on the phone how to do the questionnaire, as it will be mailed to the director. If it is not completed when you get to the center, go over it with the director. If he/she has any questions about the questionnaires, here are some aids to answering them. Remind the director to complete the questionnaire using a soft pencil and tell her that if she is in doubt, to leave it until she can discuss it with you.

Auspice/sponsorship

If a program simply rents space from a church (church-housed), they are not church-sponsored. Sponsorship implies that the church (or other entity) effectively owns/runs or pays someone else to run (as is sometimes the case in corporate programs) the child-care center. If a center is in a federal or

state building and set up for government employees, code it as 6: "corporation/business/hospital." This is, in effect, an employee sponsored program. It does not matter whether the employer (in this case the federal government) has any say in how the program is run.

Services

Full-day care means at least 6 hours a day. Programs that are open for 6 hours a day, but only allow children to be enrolled for one of two 3-hour sessions are part-day programs. Night care means care that accommodates shift work, e.g., past 7 p.m. Sick care means care beyond the usual adjustments that are made for mildly ill children. A good indicator is a separate room where sick children can be isolated with a caregiver assigned to this room.

Special-needs children

Does not include cognitively slow children, unless specifically determined (by teacher, director, or other) to be handicapped or learning disabled.

Total caregiving staff

The director should be counted only if he/she is involved in direct caregiving on a regular (as opposed to merely substituting) basis. The same rule holds for cooks, etc.

Staff titles

If the center uses different titles, use the following definitions and match staff to functional roles: Assistant teachers and aides: Provide care under the supervision of a more senior/experienced member of the staff. Teachers and teacher-directors: The lead staff person in a classroom, or in a cluster of classrooms. Sometimes called head or lead teachers. Teacher-directors combine administrative and caregiving responsibilities on a regular basis. Administrative Directors: Exclusively an administrative staff member, although may sometimes substitute in the classroom if short-staffed.

Staff turnover

If asked how to calculate, the director needs to think back to 12 months prior to the interview, consider the total number of pertinent staff who were employed by the center, and then indicate how many left.

3. Child Caregiver Interview

For any items for which response code is in years and the caregivers response is less than 1 year, code as 00 (e.g., length of time working in center.)

Own children

If the caregiver has a joint custody arrangement count the children involved as "own children."

If the caregiver answers that she has a deceased child, include it in the count here.

Age of own children

If less than 1 year old, code 0.

Include only living children here.

Own child-care arrangements

Some children will have multiple, simultaneous arrangements over the course of a day or week. Let the caregiver circle all arrangements that are used for more than 10 hours a week.

Job title

Write verbatim what the caregiver tells you.

If the director tells you something different, use the director's label for the caregiver's ID number, but write down what the caregiver tells you.

Length of work

If caregiver has worked less than 1 year, code the number of months she is planning to work.

Child Care a job or a career

If caregiver asks What do you mean by "career"?, say "a long term commitment."

Reason became a child care provider

Reason she became or is still a care provider.

Other paid work

If the caregiver works during any of the time encompassed by the three categories (e.g., only in Oct.- Nov.), code this category (e.g., Sept.- May only).

Total experience

"In the field" includes activities, such as consulting, training, or working for a child-care resource and referral agency, that are directly tied to the early childhood and child-care fields, as well as direct caregiving.

Professional membership

Err in the direction of indicating "yes" if he/she names an organization that you are not familiar with. If the center belongs to an organization (e.g., NAEYC), ask if the caregiver ever reads their materials or attends their meetings. If she says she does so frequently, give her credit for belonging.

Specialized training

Be fairly liberal with this.

Educational level completed

Probe to make sure caregiver includes some college or vocational education as well as completed degrees.

Certification

If he/she is unaware of state certifications, then he/she does not have one. Not all states offer all of these certificates/credentials. Any certificates that are issued by the state and that are used to qualify a person as a caregiver of young children should be coded as "state certification in ECE." For example, the Massachusetts Office for Children issues Office for Children certificates which specify whether a caregiver meets the state criteria as a "teacher" or a "lead teacher". These count as "state certification in ECE".

If they have state certification in elementary education, ask the questions about any specialized training/courses in early childhood.

Where caregiver got training

- a. High school (while caregiver was a student in high school)
- b. Vocational school (child-care training, nannyng, teacher's aide)
- c. College (courses or major in child development, early education)

- d. Graduate school (courses in child development, early education)
- e. Adult education (at community college, university, or high school; credit or noncredit; through extension)
- f. Conference or workshop (one or more conferences)
- g. In-service training (offered at preschool)
- h. Correspondence or television course
- i. Parent education classes

Current training

If he/she cannot remember hours, get a best guess. These are actual hours, not credit hours.

Gaps in training

Combine (E.14/15 on Form 11J) and ask this question in a non-threatening way: "Are there areas in which you would be interested in getting more information or training?" Show list or ask about specific items on list, "which areas?" Do not skip E.15 for anyone.

Center-supported training

"The director lets me do it" is not considered "support."

Future plan

Remind caregiver that responses are confidential.

Infant care training

Any transmission of information specific to infants may be counted.

Training required by the state

Training that is required by the state or by an employer for purposes of advancing from a teacher to a lead teacher (as in Massachusetts) should be coded as "yes", training that is required...

Salary as percent of household income

Household income includes income of all members of household (e.g., parents, spouse, others). This should be pre-tax income.

Wages

Convert the rate the caregiver gives you for what she charges for fulltime or part-time care to fulltime weekly rate for target child (before taxes). (If she gives you hourly rate, multiply by 40; daily rate, multiply by 5.) Have the caregiver write down the figure if there are other people around. Ask her for figure before taxes.

Hours of care to target child

If his/her schedule varies day by day, get a weekly average and divide by the total number of days/week he/she provides child care to CHILD.

Care for other children

Some caregivers may not consider their nieces or nephews as children in their care. Rely on your own observations of children who are there, and confirm by asking caregiver directly: "I can't help noticing Jimmy and Johnny. Who are they? Do they come here regularly?" Other caregivers may consider live-in grandchildren as their "own" children. But for our purposes these are "other children."

Individualized care

An individual assignment must be made as explicit policy.

Total adults who care for target child

Do not count the cook, administrative director, etc., in a center if they do not regularly provide child care beyond their primary responsibilities as cook, administrator. Clarify with the caregiver if you see people around that she has not included.

Licensing/registration of home caregiver

If the caregiver does not know what these terms mean, then he/she is NOT licensed or registered.

Length of time caregiver or child has been in center

Code in number of years; if less than 1 year, it is 0. Do not round up from 10 months or 11 months to 1 year.

Ethnicity

If there are no children in the category, code 0.

Goals for providing child care

If caregiver cares for more than one child, ask about "children" rather than "the child."

Interview with father as caregiver

Use whatever term seems most appropriate:
wife/partner/target child's mother/Mary/Alice...

D. Questionnaire Procedures

Before giving the questionnaires to the caregiver(s), remember to complete the ID information for the caregiver and the CHILD. Write in the CHILD's name on the instruction page.

The child-care visitor will leave the questionnaires with the caregiver(s) -- maximum of 2 -- at the end of the first

visit. These will be collected and reviewed at the end of the second visit. If the caregivers do not have the questionnaires finished at the end of the second visit, offer to pick them up at a later date or leave a stamped/addressed envelope with the caregiver for him/her to mail the questionnaires to you. YOU WILL NEED TO FOLLOW-UP ON THIS TO ASSURE THAT YOU GET ALL THE QUESTIONNAIRES.

It is possible that some caregivers will not want to complete the questionnaires on their own. Our goal is to get the best data possible, so, in these cases, work through the questionnaires -- one by one -- with the caregiver.

We strongly recommend that, as part of introducing each questionnaire, you have the caregiver read and complete the first item for each form. This will assure that he/she knows how to use the SCANTRON forms and understands the response choices. This will, of course, produce better data.

Introducing the questionnaires -- A sample script:

"Here are the questionnaires I told you about. Please fill them out the best that you can. There are some items that refer to CHILD and some items about child care and child rearing in general."

"Two of the questionnaires ask you about (CHILD) and I have filled in (his/her) name to remind you of this." [GO OVER "WHEN PARENT LEAVES AND RETURNS"] "The other two questionnaires ask

about your own feelings" [GO OVER THE "IDEAS ABOUT RAISING CHILDREN" AND "TAKING CARE OF YOUNG CHILDREN" QUESTIONNAIRES].

"If you feel a question does not apply to yourself or to CHILD please fill in N/A (Not Applicable) or make a short note. Do not leave any questions blank because we will think that you overlooked that item. Please do not write CHILD's name or your name on any of the forms. They are identified by ID number.

Please complete the questionnaires by yourself. We are interested in your own thoughts. Obviously, there are no right or wrong answers. Let me know if you have any trouble. I will answer any questions you may have at the end of my next visit. I will need to take the forms with me at that time (remind her of the exact date).

Thanks again!"

E. ORCE Procedures

The Observational Ratings of the Caregiving Environment (ORCE) (Form 11H) is an instrument that examines the characteristics of the child's experiences in child-care settings in two different ways: by observing the frequency of caregiving behaviors and by rating the quality of caregivers' behavior.

The Behavior (frequency) Scales record the occurrence of key behaviors in the following areas: affect, language, stimulation of development, behavior management, child's

activity, child's interaction with other children and child's self assertion. In addition, the activity setting and available and interacting adults are noted. The Qualitative (rating) Scales record the caregiver's and child's behavior in the following areas: caregiver's sensitivity, intrusiveness, detachment, stimulation, and affect, and child's mood, engagement with caregiver, activity level, sociability with peers, and attention to objects. At the end of each day of observation, global rating scales are completed. In addition, at the end of the observation on each day, one caregiver (ideally, the one who spent the most time with the target child) is asked the post-observation interview questions.

The procedure during an observation cycle is the following:

- 10 minutes of observation using the Behavior Scales
(following a schedule of 30 seconds of "observe" time;
30 seconds of "record" time), indicating which
caregiver(s) were available and which interacted with
the child during each observation interval
- 2 minutes of notetaking for Qualitative Ratings based
on the 5 minutes of observe time during the preceding
10-minute observation period
- 10 minutes of observation using the Behavior Scales
- 2 minutes of notetaking for Qualitative Ratings based
on the 5 minutes of observe time during the preceding
10-minute observation period
- 10 minutes of observation using the Behavioral Scales
- 10 minutes of observation and notetaking for the
Qualitative Ratings that incorporate the 5 minutes of
observe time during the preceding 10-minute observation
period and the current 10 minutes
- completion of the Qualitative Ratings based on all the
observed portions of the 44 minute cycle.

RECORDING TIMES

Several forms require you to know how to record time on a 24-hour clock. This eliminates the use of a.m. and p.m. The 24-hour clock starts at 1 second past midnight with 0001 and runs to midnight, which is 2400. Here are some examples:

9:00 am	= 0900
12:00 noon	= 1200
2:00 pm	= 1400
8:00 pm	= 2000
10:30 pm	= 2230

Use the 24-hour clock on the ORCE to indicate start and stop times. The start and stop times for the 44-minute observation periods are recorded on the first and last page of the ORCE form.

CONDUCTING THE ORCE

1. Conducting the ORCE at a Center

a. Before you start

Based on your interview with the director, you will know who the child's caregivers are, and whether they are specifically assigned to the Target Child. Mark this down on the Child-care ID Worksheet and the ORCE form so that you can confirm this once in the room. Also, find out the child's departure time and nap time for the day so you can plan how many observation cycles you can do. You will need to keep updating the ID information throughout your observations - keep the ID worksheet with you at all times.

b. Entering the room

The director will usually introduce you to the caregiver once you enter the room, but if not, be sure to identify yourself. Continue with the following script:

"As you know, I will be observing CHILD this morning. I want to see what a typical morning is like for him/her. I want to see how he/she acts around the other people in the room and how he/she pays attention to the things in the room. I want to find out what kinds of experiences he/she usually has. For the observations to be accurate, it is important that everyone act as naturally as possible and just do what they would be doing if I weren't here. I know this is easier said than done, but try to do what you would normally do. The purpose of these observations is really just to find out how children spend their time in child care. I will be following CHILD's activities, and I may, therefore, need to go in and out of the room. I'll try not to be disruptive. If you just ignore me, I hope that the children will too."

"Now I just need to make sure that I have everyone's names and positions straight." (Complete the information about caregivers at the top of the form.)

"Is (caregiver's name) (child's name)'s primary caregiver?

Is _____ the lead/head teacher/caregiver for the group?

Who besides _____ and _____ has responsibility for (child)?

If there are any other adults present, who are they?"

Make sure that you know the names of the caregivers whom you will be observing (up to a maximum of eight). Try to keep your conversation with the adults and your interaction with the children to a minimum. Ask if there is a particular spot where you can sit or stand. Look for a place that is as "out of the way" as possible, and yet provides a good view of the classroom, so there will be as little need as possible to move to follow child or caregiver. Do not compliment the children or any aspect of the child-care arrangement. This will appear "judgmental" and may invite unnecessary questions.

Allow 10 minutes before you begin the observation. That will allow time for the room to resume its normal routine. It will give you and the children time to "settle in." At this time children may come over to you and try to get your attention by bringing a toy or by talking. Your job is to be as neutral as possible. This means not rebuffing the child, but not being overly encouraging. It is a fine line and not an easy task, but you will find your own way that is comfortable.

c. Behavior Scales

Observing the caregiving environment

You will be observing and recording the behavior of the target child and of any caregiver directed toward that child. Once you begin the observation period, focus on the target child.

If the child leaves the room, follow her/him. If the group goes outside, accompany them. During this observation try (as impossible as it seems) not to let the target child know that she/he is being observed. This means looking at the group and avoiding eye contact with the child. As they occur, make mental note of behaviors that you know are on the checklist. Keep your attention on what is happening to the child during the "observe" period. If you are afraid you will forget some behavior that occurs, you may record it during the observe period as long as you do not miss any other behaviors that occur while you are glancing down at the record form.

Completing the Behavior Scales

Use the "record" periods to check systematically through the list of behaviors from top to bottom to make sure you have noted everything that happened. You will have 30 seconds to record your observations for the preceding half-minute. Accuracy is critical. For most of the scales, either the behavior occurred (mark it), or it did not (leave it blank). Even if the behavior was repeated more than once in the interval, you can mark it just once. For the caregiver's response to the child's negative affect, the coding is slightly more complicated: you must first decide if there was an opportunity for the response to occur -- i.e., the child expressed negative affect -- and then whether the

caregiver responded (check Y (yes)) or did not respond (check N (no)).

d. Qualitative Scales

Completing the Qualitative Scales

In using the Qualitative Scales, you will exercise your clinical sensitivity and judgment. You are interested in the overall quality of the caregiver's or child's behavior.

For the Qualitative Scales, focus explicitly on the dimensions of caregiver and child behavior tapped by these scales. Be aware of all the caregivers who interact with the target child.

The qualitative scales are coded for caregivers who are involved with the target child for at least two of the four 10-minute segments in a 44-minute observation. If one caregiver is exclusively involved with the child, additional caregivers will not be coded on the qualitatives, even if they are present throughout the observation. If no caregiver is ever involved, then all caregivers present (up to a maximum of 3) will be considered responsible for the child and all will be coded.

Each set of Qualitative Ratings is to be based on 44 minutes of observation. During the first 34 minutes, the observer completes the Behavior Scales and make notes for the Qualitative Ratings in the two 2-minute breaks. During the next 10 minutes, the observer should focus explicitly and solely on the Qualitative Ratings. To help observers remain on task during

this time, they should take longhand notes or make preliminary ratings of caregiver or child behaviors as they relate to each scale.

In the definitions of each scale, we have avoided applying absolute frequencies of occurrence for assigning ratings. On occasion, raters will not be able to observe for the full 44 minutes. Also, frequencies may be dependent on specific activities in the child-care setting. Consequently, in assigning ratings, you should use a two-step process. The first step is to ask, Is this dimension "characteristic" (a rating of 4 or 3) or "not at all characteristic" (a rating of 2 or 1) of the person being rated? Once this decision is made, then determine if the dimension is "sort of" characteristic or "very much" the case.

Ratings for most of these scales should be based on both the quality and quantity of behavior. Thus, evaluations should be made taking into account the quality of the observed behaviors in relation to the proportion of the time they were observed. Ratings of 1 and 4 should be reserved for those observations which could be considered either problematic or exceptionally advantageous, depending on the specific scale.

e. Post-Observation Interview with Caregiver

At the end of the visit, interview one caregiver to determine whether your observations were "typical." If there is more than one caregiver, interview the one who interacted most

with the child. Do not change the answers the caregiver gives you. He/she may contradict herself by saying "yes" to question 1 and then "yes" to several items on question 2. Do not change her answers to make them consistent.

f. End-of-Visit Ratings

At the end of each day's visit, complete the End of Visit Ratings of overall quality of child care, etc. Base these ratings on your observations during the entire day's visit.

2. Conducting the ORCE at a Home

The ORCE procedures will be the same in home settings (child's own home, sitter's home, family daycare). However, your experience may be different. Although the setting may seem more informal, it is important for you to remember your role of objective observer and try not to be drawn into the activities of the environment. In addition, there may be more opportunity for informal conversation. By emphasizing to the caregiver that you want him/her to act as naturally as possible and to pretend that you are not even there, you are letting the caregiver know that you need to focus your full attention on what is happening in the setting.

Basically, you will follow the same sequence as in the center except that there will usually not be multiple caregivers.

Before you begin observing, when you first get to the home,

spend a little time (not more than 10-15 minutes) chatting with the provider as an introduction and warm up. Caregivers may be nervous during this procedure, and so may you. You should spend a little time at the beginning just getting acquainted with the caregiver. The conversation might be about common or mundane things that any two persons might talk about. This will allow you to get some sense of who lives in the house and what their roles are in the family. Many times there will be another child present at the time of the interview, and it may be necessary to devote some attention to that child as well as to the key child. This warm-up period offers a good opportunity to say something nice about the child (refer to the child's appearance or behavior, whatever comes easily to you and can be done honestly).

After the first ORCE subcycle (10 minutes) and the completion of the preliminary Qualitative Ratings, if you have any reason to suspect-caregiver is holding back or showing off, pause the audiotape while you tell the caregiver that this is what you will be doing for the next couple of hours. Ask her/him -- in a casual way -- if he/she did anything different because you were there (didn't leave the room, didn't play with the child, etc). If she says she did, encourage her again to continue business as usual as if you weren't there. Then begin the audiotape again to begin the next observe cycle.

3. Observer's Interaction with Caregivers

Whether at a home or a center, the observer should make all effort to put the caregiver(s) at ease (smiling, accepting a cup of coffee and a chat at the end of the observation, etc.). You are a person, not a video camera (despite the fact that your observation record should be as accurate as a camera's). You have feelings, reactions, good sense, and judgment that should not be left behind at the door. You should make your role as observer clear to the caregiver; you are there to watch, not to intervene (or babysit). We suggest that you state explicitly that "I am not allowed to be left alone with the children." The caregiver should behave as he/she would if you were not present. Thus, in arrangements with only one provider, the provider may need to leave some children unsupervised for brief moments (e.g., bathroom breaks) and you will momentarily be left alone with the children. On the other hand, if the caregiver asks you to watch the children while he/she makes a phone call in a different room, you must refuse politely and say that you are not allowed (for liability reasons) to be left alone with the children even if he/she would ordinarily make such calls. Clearly, if a child is in a different room from the caregiver and is in imminent danger, you cannot stand by and watch a catastrophe happen. You must find ways of ensuring that your presence, including your nonintervention, is not affecting what is going on in the room (e.g., older children hitting you or each other because you are

so unresponsive). It may help put caregivers at ease if you say something about the unusual role of an observer who is basically not allowed to act naturally herself.

Try to put the caregiver at ease by reassuring him/her that you are interested in observing a typical day, and that you will try to be as unobtrusive as possible. Avoid eye contact with the caregiver and the children so as not to invite conversation or interactions, and try to keep your facial expression neutral. If the caregiver seems eager to talk, tell her there will be time during the interview to cover that particular issue, and make a note to talk about it later -- "I'm afraid I won't finish up in time; let's discuss that later during the interview" might be a helpful deterrent. Also, remember that the closer you are to the caregiver, the more likely it is that you will influence his/her behavior, so try to find a "vantage point" away from the caregiver from which to observe.

4. Guidelines for Behavior Scales

a. People present

Available adults:

Code the number of adults (over 12 years of age) who are in the same room as the child or, particularly in home settings, within earshot of the child, even if not in the same room. They are not necessarily paying attention to child; they may be involved with their own activities or with other children. Code

this at the beginning and at the end of the observation cycle. When the child is out of his/her regular care setting (i.e., the home or center), a more "functional" definition of "available" must be used. Adults standing in a check-out line at the store or bank or library should not be counted. There must be some likelihood that these people would interact with the child; they must be part of some functional "group" of which the child is also part (as would be the case if they were in the child's class at a center or in the child's home). The reason to make this distinction is (a) to make the coding for parks, etc. more comparable to the coding for centers and homes, and (b) to use the coding as the basis for calculating meaningful adult-child ratios. If the park or playground is, in fact, a regular child-care setting -- that is, the caregiver takes the child there every day and they see and interact with the same people there every day -- then the "functional group" would consist of those adults and children that they see and interact with every day.

Describe each of these adults as a caregiver, friend, volunteer, target child's parent, other parent, etc. For the purposes of the ORCE, a caregiver is defined as anyone who provides regular (at least 10 or more hours per week) care to the target child, or, in the case of group care, in the target child's room. The caregiver may or may not be specifically assigned to the target child. In group care this includes "floaters" who are regular caregivers in the program but divide

their time across multiple rooms as long as they typically spend at least 10 hours a week in the target child's room. Some programs will explicitly define caregivers as floaters; others will not. This doesn't matter for our purposes. "Caregiver" also includes "student" teachers, parent volunteers, etc., who may or may not be paid, who spend at least 10 hours per week, at regular times, in the target child's classroom. "Caregiver" excludes any adult who does not spend at least 10 hours a week, at regular times, in the target child's classroom, such as a center director who periodically passes through the classroom, a parent in a parent co-op who volunteers for less than 10 hours a week, a music teacher (who will undoubtedly spend less than 10 hours a week in the target child's room), etc.

Available other children:

Code the number of children (12 or under) who are in the same room as the child. They may not be paying attention to the child; they may be involved with their own activities, but they are, at least, awake and visible to the child. Code this at the beginning and at the end of the observation cycle. If there are no other children, code 00. Children in the park, playing on the swings, running through the grass, minding their own business while the target child is in a stroller next to the caregiver should not be counted as available.

YOUNGER INFANTS: number of children present who are under 12
 months of age

OLDER INFANTS: number of children present who are 12-18
 months of age

TODDLERS: number of children present who are 1 1/2 to 3
 years old (18-36 months)

PRESCHOOLERS: number of children present who are 3 to 5
 years old (36-72 months).

KINDERGARTNERS: number of children who are 5 years old

SCHOOLAGERS: number of children present who are 6 to 12
 years of age

Asleep children:

Record the number of children for whom the caregiver(s) is responsible who are not "available," but sleeping. Although these children are not available partners for the child, they may affect the caregiver's availability.

b. Specific Scales

ADULT AVAILABLE

For each 30 second period indicate which caregivers were available in the same room or within earshot. If we are to link up the observed behavior of specific caregivers with their responses on the Interview and Questionnaires, as well as with their Qualitative Ratings, it is necessary to keep all the

caregivers who interact with the child distinct during the ORCE recording. On each ORCE page of a given ORCE cycle, therefore, the caregiver labelled as "Caregiver #1" or "Caregiver #2," etc. must be the same person; i.e., If Sally Jones is Caregiver #1 in the first ORCE 10-minute segment then Sally Jones must be Caregiver #1 in the third ORCE 10-minute segment and on the Qualitative Ratings at the end of that cycle. To keep the caregivers straight, write a mnemonic for each (red curly hair, tall blonde, Sally, etc.) Include all adults (people over 12 years) who interact with the child here. We have allowed room for up to 8 different caregivers for a cycle. If you run into situations where more than 8 different adults interact with the child during a single ORCE cycle, use the "Caregiver #8" slot for all of these "extras."

An adult talking to the child on the phone is not available.

ADULT INTERACTING

Code which adult(s) interacted with the child during the 30 second interval. Code a caregiver as interacting even if she merely shouts 'coming' from the other room. If "other activity with adult" is coded under child's activity, "adult interacting" would also be coded, even if the caregiver doesn't actually "interact" with the child.

An adult talking to the child on the phone is interacting.

BEHAVIOR SCALES

DOUBLE CODING RULES

Double coding refers to coding the same behavior more than once, not using the same scale more than once in a 30 second interval. All scales on the ORCE may be used in any given 30 second interval.

In general, the ORCE has been designed to avoid double coding of the same behavior on different scales within the same category. The exceptions are indicated on the form by underlining.

The following rules guide double coding both within and between categories:

AFFECT

- (1) Responds to negative affect must be double coded with a subsequent scale in the same or a different category if it fits one of these scales (e.g., positive physical, speaks positively, asks question, or facilitates). If it does not fit one of the other scales then it is not double coded.
- (2) Shared positive affect and positive physical contact may both be used in a 30 second interval: e.g., laughing together is shared positive affect and positive tickling is positive physical contact.

(3) Shared positive affect may also be used in the same interval as a verbal scale: e.g., smiling at each other would be shared positive affect and "coochy-cooing" would be speaking positively.

(4) Positive physical contact is not double coded with facilitates or stimulates, but a caress could occur within physical care or while watching TV, etc.

LANGUAGE

(1) Responds to vocalization must be double coded on another language scale if it is language.

(2) The other language scales must not be double coded with each other.

(3) Language may be double coded with a scale in another category (stimulation, behavior management, or affect).

STIMULATION

(1) The same behavior is not double coded as cognitive and social stimulation.

(2) Stimulation is not double coded with behavior management (facilitates), but it may be double coded with affect and language.

BEHAVIOR MANAGEMENT

- (1) The same behavior may not be double coded within this category. Code in order of priority listed.
- (2) Behavior coded for behavior management may be double coded as language or affect but not as stimulation.

ACTIVITY SETTING

- (1) The child may be in only one activity setting at a time (although more than one may occur in the same 30 second interval).

CHILD'S ACTIVITY

- (1) Only watching TV can be double coded with other scales in this category (e.g., watching TV while eating (physical care), singing a song (other activity without objects)).
- (2) The other activity scales may not be double coded; code in order or priority listed.

CHILD'S INTERACTION WITH OTHER CHILDREN

- (1) The same behavior may not be double coded within this category.

CHILD'S SELF ASSERTION

(1) The same behavior may not be double coded within this category.

SCALE DEFINITIONS

AFFECT

Responds to negative affect

The caregiver responds to the child's negative affect. Negative affect includes fussing, fretting, crying, screaming, whining. It must be clearly negative and audible, not just a frown or whimper. It may be prolonged. It should demand a response. (If in doubt, call it a vocalization.) The response may be verbal (e.g., "Oh, Sandy, why are you crying?") or nonverbal (e.g., picks up and comforts.). The adult does not necessarily meet the child's needs with her response. When the child expresses negative affect, the caregiver does not have to be within sight or even in the same room for her response (or lack of it) to be coded. If the child expresses negative affect, code Y = the caregiver responded or N = the caregiver did not respond. If the caregiver ignores one or more expression(s) of negative affect, or if the negative affect is continuous, if she ignores more than 5 seconds of negative affect, she receives an N. If she responds to one expression of negative affect, she

receives a Y. Thus, she may receive both an N and a Y during a single 30-second observation interval. If the caregiver's response is verbal, it should also be coded on a language scale other than responds to vocalization. If it is physical, it may also be coded as positive physical, stimulates, facilitates, restricts, or negative physical.

Shared positive affect

The caregiver and child express positive affect toward each other within the same observation interval. They laugh or giggle together, smile at each other, the child makes positive sounds while face-to-face with a smiling caregiver. The two do not have to be in direct physical contact or proximity but they do have to be involved with each other. The interaction does not have to be one-to-one; it may involve more than one child or more than one adult.

Positive physical contact

The caregiver and child have positive physical contact. The caregiver holds or touches the child -- warmly and comfortingly, affectionately, or playfully. Positive physical contact includes the caregiver's holding the child on her lap, but it is not simply picking the child up to move him/her somewhere and it is not having the child simply sitting on the caregiver's lap and the caregiver not touching the child in any

other way. It may occur in the context of caretaking, but it is not routine caretaking alone. It must be active, intentional (not simply touching the child's arm in passing or patting the child's behind repeatedly and absentmindedly while doing something else or holding child's hand while dragging or to keep from running into traffic.) Examples are hugging, kissing, rubbing, stroking, tickling, rocking, swinging, clapping, patting, holding close, hugging, cuddling, rubbing noses, holding in arms while feeding, holding on lap. If the child does the positive physical action to the caregiver and the caregiver ignores it (does not respond physically), this would not be coded.

LANGUAGE

All language coded in the ORCE is language by the caregiver to the target child -- either alone or as part of a group of children. Each utterance is coded on only one language scale except for responds to vocalization. This scale must be coded on one of the other language scales as well. The order in which the scales are listed is the order of priority for coding. For two of the scales (responds to vocalization and other talk to child) the caregiver talks to the child individually. For five scales (speaks positively, speaks negatively, asks question, gives direction, reads) the caregiver may be speaking to the child alone or as part of a group. The final scale (other talk to

group) refers to language directed to the target child as part of a group; a group consists of three or more children.

Responds to child's vocalization

The caregiver listens to the child's vocalization and then responds vocally. This does not include responding to frets, cries, or laughs; these are not vocalizations but expressions of negative and positive affect, and responses to them would be coded on those scales. The child's vocalizations are words or babbling sounds. Example: the child says "Uh, uh." and points and the adult says "Doggie. That's a doggie." Child says "Uppy." and the caregiver responds "Shall I pick you up?" The child says "Me go." and the adult says, "You want to go out?" If the child articulates specific words, the caregiver uses the same words, extends the child's utterance, or answers the child's question. If the caregiver initiates the child's nonverbal utterance, this is responds to vocalization, but it is not one of the other language (speech) categories.

Speaks positively to child/ren

The caregiver says something warm, affectionate, or complimentary to the child, e.g., praises, says "I love you," "You're such a cutie," "Hurray! You did it!" "Oh, look at how well you're climbing those stairs -- all by yourself." "Good

girl." "Oh, you silly!!" "Oh, you fat little toad!!" The utterance may be warm in tone of voice or content of utterance.

If in doubt, do not code; the utterance should be clearly positive.

Speaks negatively to child/ren

The caregiver says something negative to child: finds fault, threatens, speaks with hostility, snaps, insults, scolds, criticizes, yells. Either the words or the intonation is negative. Examples: "Another dirty diaper??? I just changed you!" (said harshly) "Stop dragging that blanket all over the house right now!" "Did you hit Mary? Shame on you!" "Stop that right now. Wait till your mother gets here!" This scale goes beyond a simple "no"; it must be a criticism or a derogatory statement. It may be double coded with restricts activity.

Reads aloud to child/ren

Caregiver reads from books, magazine, paper, or any other written material to the child or to the group that the child is part of. This can be reading single sentences or a complete story, but it is definitely reading, not just pointing at pictures in a book (which might be stimulates cognitive development). The child may or may not be listening and learning; the point is only that the caregiver is reading and

the child is there. Examples: reading a story at circle time, reading as child falls asleep, reading poster on wall to child.

Asks question to child/ren

The caregiver asks the child a question. Any question, regardless of content, should be coded if it has not been coded on a higher language scale (speaks positively, speaks negatively, or reads). Examples: "Are you hungry now?" "Are you excited to see daddy?" "Do you want me to tickle your tummy?" "Who is that? Is that your daddy?" "Where is your nose?" "What do you have?" "Do you want a turn on the swing?"

Code tag questions "..., don't you?" as questions.

Gives direction to child/ren

The caregiver tells the child to do something (or not do something), gives direction, suggestion, order, demand, or request. "Put them in here." "Go pick up your coat." "Put on your shoes, please." "Here, color with these crayons." "Go find your brother." "Say 'kitty'." "Don't touch the radiator." The demand may be for an action that the child is willing to do or unwilling to do; the child may comply with the request or not comply. This refers to an actual action that the child can do, not a change in the child's emotional state (e.g. Don't cry. Don't worry. C'mon, smile. Cheer up. Have a good day.) Gives direction is directing the child's activity, not describing

("Let's go in now") or comforting ("Don't Cry"), or a general warning ("Be careful." "Don't fall.")

Other talk to child

Caregiver directs an utterance to the child individually (or to the child and one other child) that has not already been coded in one of the higher language scales. The utterance should contain words not just noises. ("Shh" is considered a word.) A single sentence will do. Examples: "Let's go outside." "The bottle's empty -- no more." "Let's put your bib on." Singing also would be other talk. If the caregiver is singing along to a record, this would be coded as other talk to child only if it is directed to the target child; the caregiver would have to be looking at the child, possibly holding the child, not vacuuming or doing the dishes or looking out the window. If the observer cannot hear what is being said clearly, code it as other talk.

Other talk to group

The caregiver speaks to a group of children that includes target child an utterance that has not been coded on a higher scale. Target child may or may not be listening but the utterance is clearly directed to him/her as part of the group.

A group consists of our child plus at least two other children.

STIMULATION

Stimulates cognitive development

The caregiver stimulates the child's cognitive or sensorimotor development -- teaches, encourages a skill; gives child instruction of some sort. Tries to give the child a new idea or experience. The stimulation must be directed toward the target child. The child may be in a group of children who are receiving a "lesson," but if the child is not really part of the group that the adult is teaching -- he is sitting to one side attending to something else, for example -- this would not be counted. It should be clear that the child is paying attention to the caregiver's stimulation attempt and potentially learning something. There should not, however, be any judgment of the age appropriateness of the stimulation. The interaction may be playful and enjoyable (e.g., singing the ABC's), but it must involve teaching, education, instruction, stimulation, not just soothing or simple play (like rough and tumble). Simply handing the child a toy does not suffice, even if the caregiver says "Look at this." (This would be facilitates.) Giving a fussy child something to keep it quiet also does not count. (This would be responds to negative affect.)

Stimulation would include teaching a motor skill like walking, climbing, rolling over. It would include teaching a cognitive skill like counting, letters, colors, the ABC's, how to

put a bead in a bottle. It would include teaching a self-help skill like putting on shoes, how to drink from cup; how to pick up a small object. It would include deliberately teaching child the name of an object; e.g., "This is a ball." "Look at the ball." "Say 'ball.'" -- while the child or the adult is pointing at the ball or reaching for the ball, or if child asks for the name of an object or for the object (points, reaches, says "Whatzat?") and the caregiver says "That's a ball." It does not include just using a single word label as in "Put the cup down." It includes teaching about an object (toys, puzzle, mobile) by showing how it works or describing its attributes ("It's red. It bounces."). It includes encouraging the child to perform a skill he is just learning (dancing, climbing, stringing beads, etc.). It includes teaching the child to pretend (symbolic function). Reading to the child is most likely cognitive stimulation -- if it's educational, if the caregiver shows the child pictures, if it provides information about the world, etc. Reading that is not cognitive stimulation would include reading to keep the child quiet or put the child to sleep -- when it is clear no teaching (or learning) is going on. When in doubt, don't code.

Stimulates social development

The caregiver stimulates the child's social or moral development. He/she encourages children to interact socially (says something about playing together) or teaches a social rule.

For example: rolling a ball between two children; helping them take turns on a slide, suggesting that they pull each other in a wagon, telling one child to look at what another child is doing. He/she teaches how to play a social game with him/her (e.g., patty cake or peek-a-boo) or with other children. He/she encourages children to share, cooperate, take turns, interact with her or with each other. He/she forbids child to hit another child, take his toys away, etc. She teaches social skills, rules. Example: "Be careful you might knock baby over." "I really like the way you shared your ball with Jimmy!" He/she explains reasons for rules/expected behavior -- for example, tells the child (the target child or another child who is interacting with or getting in the way of the target child) why it is that he/she must do something. The caregiver may use a pet to teach gentleness, respect; this would be social stimulation. (If caregiver is teaching about hugging or kissing it would be coded here. Code social stimulation if the caregiver is teaching the child study child is interacting with about social rules/interaction. If caregiver introduces a social game (like "Ring Around a Rosie") this would be coded here not as facilitates.)

BEHAVIOR MANAGEMENT

Facilitates child's behavior

The caregiver helps, assists, or entertains child in some way. Caregiver may be responding to the child's need, bid, or signal (vocal or gestural), or initiating the action. The child may be in a predicament, unoccupied, playing alone, or interacting with the caregiver. Examples: helping child put on shoes, slide down a slide, moving chair out so child can sit down, retrieving a fallen toy, moving something closer so child can reach it; removing child from high step or from climbing up on a wobbly bookcase, removing another child who is threatening to hurt the child; suggesting an activity: "Why don't you ..." "Look at this." "Go get it." (the ball); or offering a choice: "Would you like to play with the blocks?" "Would you like to play with the blocks or the cars?" "How about playing with the?"; extending child's play by offering more ideas, materials; introducing a toy -- winding it up and handing it to the child; responding to child's bid by giving him what he is asking or crying for (more than attention). Behavior on this scale should not be double coded with stimulation or restriction. The distinction between "facilitates" and "stimulates" is that "facilitates" is not explicitly educational; "stimulation" is. But as in cognitive stimulation, if our target child is part of a group that is being entertained, target child must be paying

attention to the adult. If in doubt between facilitates and cognitive stimulation, code facilitates. Facilitates does not include giving the child food (unless it is in direct response to the child's demand).

Restricts child's activities

The caregiver restricts the child's activities, either verbally or physically. Verbally, caregiver prohibits the child's action, whether the action is appropriate or not. Examples: Says "No!" "Keep the crayons on the table." "Take that out of your mouth." "Turn the shirt right side out." "Stop fighting." Prohibits things child wants to do. Examples: Says "No, you can't paint right now." "Come back here, you are not going out." (The caregiver may or may not offer an explanation of justification along with the prohibition.) Physically, caregiver restricts child's actions with a physical barrier to block the child's movement, taking away a toy the child is playing with, or removing the child from an activity he is enjoying. The caregiver may be restricting a child physically by holding him, but it is not coded in this scale if it is not against the child's will. If the child is happily sitting on the caregiver's lap, this would not be restricting. If the child is not trying to escape or do something else (wriggling, fussing, reaching, etc.), then it is not restricting. It would not be coded in the context of play unless the child clearly didn't want

to play. Code in each minute that activity is restricted. This should be coded according to the caregiver's action rather than the child's reaction to her behavior. It must be clear that the child's activity/wishes/desires or potential activity/wishes/desires are being thwarted, but it is not necessary that the child respond to the restriction negatively (although if he/she does, it is even easier to see that it is a restriction). Some children respond to restriction negatively; others ignore the restriction and turn to other activities. For both, their activities have been physically restricted. What would not be physical restriction would be a baby gate at the other end of a room that the child never gets to, physically holding the child in a hug that the child is enjoying, or taking away a toy that the child is obviously through playing with.

If caregiver says something "restrictive" in a playful way and does not really restrict child's activity, this would not be restricts. If he/she redirects child who is in a predicament (e.g., about to fall down the stairs), this would be facilitates rather than restricts. Examples of restricts: "Let's not bother the observer; come over here." "Don't splash me when I have my clothes on." "We don't need the light on" (i.e., "Stop playing with the switch.")

Restricts in physical container

The child's mobility or activity is restricted by being in a physical container. This is coded whether the restriction is seen as appropriate or not, pleasant or not. The experience can be a positive one for the child; the child may be playing in the container. Containers include: highchair, swing, sassy seat, crib, playpen, backpack, infant seat, walker, etc. If the child can get out of the container without adult assistance, it is not "restricts" (e.g., play car, swing, wagon, etc.).

Uses negative physical actions

The caregiver touches the child in a negative way (hitting, shaking, slapping, smacking, yanking, pinching, pushing, kicking, etc.) or puts in a physically adverse situation in order to punish or control the child (e.g., out in the cold).

ACTIVITY SETTING

An activity setting must last at least 5 continuous seconds to be coded.

With adult (and child/ren)

The child is part of an activity in which an adult is involved. The child and caregiver may be alone, and the interaction one-to-one, or the child may be part of a group of

interacting children and adults. The caregiver may or may not be attending to the target child exclusively, but he/she must at least be involved with him/her (e.g. eye contact, physical contact, verbal contact), and the interaction must last at least 5 seconds continuously. Just a passing nod or word or just visual supervision from a distance is not sufficient to receive this code. If the caregiver is physically very close to the child (within the caregiver's arm's reach; i.e., 2 1/2 feet) and watching the child at least occasionally (even if she is not talking to the child), or if she/she is pushing the child in a carriage or stroller, or if he/she is at or on the same piece of equipment (e.g., table) and watches occasionally, this would be coded on this scale. If the caregiver is "vegging out," or has her back to the child, even if she is physically close to the child, this would not be coded. If the child is playing with other children and the caregiver is watching from a distance but not interacting with them, this would be activity with child/ren not activity with adult and child/ren. If the caregiver is talking to a child (not the target child) in a group that includes the target child, and she is talking about the group's activity, this could be seen as being involved with the target child.

With child/ren only

(1) The child is playing with another child. They may be playing in parallel, i.e., with the same materials, interactively, imitatively, or cooperatively. Or (2), the child is playing at the same piece of equipment (slide, swings, sandbox, sandtable, table) as another child. Or (3) the child is within 2 1/2 feet of another child (the two children's arms' reach). They may be eating in adjacent highchairs, sitting on adjacent toilets, or painting at adjacent easels.

Alone

The child is neither near (within 2 1/2 feet) nor involved with another person.

CHILD'S ACTIVITY

All the child's activities that last for at least 5 continuous seconds are coded on one of these scales. There can be more than one for each interval if more than one activity occurred for more than 5 seconds. Only if no activity in the interval lasted 5 or more seconds would this category be left blank. With one exception, the activity scales are mutually exclusive; a single activity cannot be coded on more than one of these scales. The exception is watching TV. This scale may be double coded with another scale in this category. For activities other than watching TV, if an activity seems to fit more than one

scale (e.g., the child is engaged in activity with objects interspersed with brief intervals of watching), code it at the highest level observed (i.e., in the order of priority in which the scales appear on the form).

Physical care

Child is given physical caretaking by caregiver or engages in physical care activities by himself. Physical care activities are those necessary to take care of the child's physical needs. Examples: dressing, diapering, washing, going to bathroom, taking a bath, feeding, eating, drinking, rocking to sleep, putting on a sweater. Physical care does not include giving the child a pacifier or a wipe of a nose that lasts less than 5 seconds.

Other activity with objects

The child is involved in an activity with an object or objects. These objects would include books, toys, paints, kitchen utensils, pets, food that someone other than the child is eating or food that the target child is doing something with other than eating, playground equipment (swings, slide, trampoline, jungle gym), tricycles, water in a swimming pool, even dirt and sand -- if they are being used as objects (i.e., the child is playing with them, building, experimenting, exploring). The object must be in the child's hands or within his/her reach and the child is clearly involved with it. The

child is interested in the activity, not just passing time. He is exploring, manipulating, or playing with the object. Just sitting together on a couch is not activity with object.

Other activity without objects

The child is involved in an activity that does not involve objects, e.g., singing songs, gross motor activity (running, jumping, walking on a line), rough and tumble play, listening to a story (but not holding or looking at the book), playing a game, holding an infant, tickling the caregiver (or vice versa). Sitting or walking on the ground, sand, or water, is activity without objects, not activity with objects. "Pretending" about non-existent objects is without objects. Talking about objects that are not actually present or touchable is without objects.

Watching/unoccupied/transition

The child is awake, but not engaged in any observable activity. He may be waiting for the next activity to start (before eating, before going out), or he/she may be watching other people (adults or children) but not interacting with them. The other people are ignoring the child. They may be across the room or close up, but they are clearly not interacting with the child. It may be the observer who is being watched by the child. The child may be watching an event or object at a distance, but he cannot reach the object and no one is talking to him about it.

The child is not doing anything else at the same time (using or exploring a toy, interacting with anyone, being held). He/she may be holding a toy in his/her hands or mouth, but is not exploring it. He/she may be wandering around the room or walking from one place to another but not running or jumping in fun. He/she may be alone in the crib and falling asleep. He may be in "time out." He may be sucking his thumb or a lollipop but is not exploring them. He/she may be near other children or adults or alone.

Watching TV

The TV is on and the child is looking at it. Do not code if the TV is simply on throughout the visit. Code only in those intervals that the child watched the TV for at least 5 continuous seconds.

CHILD'S INTERACTION WITH OTHER CHILDREN

"Other children" are children under 13 years old. Code behavior in this category by judging what actions are directed to the target child rather than on how the target child reacts to the overtures of the other children. Code by judging what the target child is doing rather than on how the other children react to his/her actions and overtures. If the target child initiates the interaction, he/she must be aware of the other child's behavior; accidental bumps, kicks or hits in head with a ball should not be coded.

Positive/neutral interaction

The child gives or receives overtures from other children -
- e.g., smiling, offering toys (even if they are not accepted), accepting toys that are offered, playing interactively or cooperatively, touching, kissing. This is not a measure of high level, truly interactive engagements between children; quite rudimentary attempts at interaction will do.

Negative interaction

The child gives or receives unfriendly overtures from other children -- e.g., hitting, taking away toy that child wanted or was playing with, fighting. If one child takes another child's food from his/her tray and the "victim" doesn't express

dismay, it would not be negative interaction. The child must have been eating or playing with the object.

CHILD'S SELF ASSERTION

Child says "no"/refuses

The child exhibits autonomy or assertiveness to adult/caregiver by saying "no" or "mine" or some other emphatic but nonangry expression, verbal or nonverbal. For example, shaking head "no," holding object tightly to self, turning back to caregiver, or not doing what the caregiver requested, but without acting angry or defiant. Must be a deliberate refusal, within the 30 second period, not just ignoring the caregiver's suggestion as if the child didn't hear or understand. The child's refusal may be whiney, but it is not angry. If child is responding negatively (refusing or crying) to a negative stimuli (e.g. being hit, getting hurt, something painful,) this would not be says 'no' (or acts defiant). If the caregiver is trying to get the child to eat his peas or take his medicine and he turns away, shakes his head, etc. this would be says 'no.'

Acts defiant

When someone (an adult/older child ≥ 13) tries to control the child, through prohibitions, suggestions, questions, or

physical actions, the child acts defiant: angry, yelling, aggressive, or intensifying the prohibited behavior.

5. Guidelines for the Qualitative Scales

a. Caregiver rating scales

SENSITIVITY/RESPONSIVENESS TO DISTRESS

This scale focuses on how the caregiver responds to the child's cries, frets, and distress. It is judged in the following three ways:

Proportion of distress signals responded to. What proportion of distress is responded to.

Latency of response. How long does it take the provider to respond. Mild fussiness does not require the caregiver to respond as quickly as does the child's acute distress.

Appropriateness of response. Appropriateness of the adult's behavior should be inferred by its effectiveness in soothing the child coupled with a consideration for its fit with the intensity and cause of the distress

Caregivers who do not acknowledge distress, even if the child self-soothes, should be judged to be less sensitive than those who do acknowledge the distress, however short-lived.

Caregiving responses to the child's distress generally involve speaking sympathetically to the child, approaching the child, offering help or intervening, changing an activity or its pace, offering toys, patting, picking up, holding closely (especially in a ventral/ventral position), and rocking. Any of these or other behaviors can be considered sensitive if they appear to have the effect of comforting the child. If the

caregiver's first response to the distress does not soothe the child, the episode should be rated as insensitive (even if the response was immediate) unless the caregiver proceeds to offer a "fuller" response (i.e., more proximal soothing behaviors). Some response, however, unless totally perfunctory, is judged as more sensitive than none at all.

As a sign of their growing maturity, some toddler crying increasingly occurs in situations of frustration. While, in general, more proximal responses are more appropriate than less proximal (e.g. squatting at the child's level and offering concrete help rather than a distal spoken response), close holding is not necessarily more appropriate than other caregiver behavior that addresses the source of the frustration.

Ratings on this scale are composed of both qualitative and quantitative dimensions. The proportion of signals responded to and the latency of response time should be evaluated in relation to the quality (appropriateness) of the response. A rating of 1 should be given to a caregiver who never responds to the child or who responds very slowly and infrequently, and generally inappropriately. If some appropriate responses occur but more are not or responses are generally delayed the caregiver should receive a rating of 2. A caregiver might also receive a 2 if the responses are perfunctory. If a greater proportion of distress episodes are responded to and given appropriate responses than not, the rating would be a 3. A rating of 4 should be given to

those caregivers who exhibit immediate and exceptionally sensitive and appropriate responses in almost all situations.

If a caregiver other than the focal caregiver responds to the child's distress, it is not expected that the focal caregiver respond. These instances of distress should not be considered in evaluating sensitivity to distress.

More often than not there will be few or no instances of distress. A 9 should be given if there are only fleeting mild instances of distress.

1 = Not at all characteristic. This rating should be given to caregivers who are very insensitive and unresponsive. When the child cries or frets, the caregiver responds not at all, or very slowly or inappropriately. If there is a response, it is only after the child becomes very demanding, and the response is so delayed that it cannot be construed to be responsive to the child's behavior. A caregiver who typically appears oblivious or punitive to the child's distress would receive this score.

2 = Minimally characteristic. This rating should be given to caregivers who display infrequent or weak sensitivity/responsivity. The caregiver responds rarely or slowly to child's distress signals, and appears more unresponsive than responsive. The responses tend to be minimal or perfunctory or otherwise inappropriate. For example, the caregiver may talk to or briefly pat a crying child, but does not pick up the child. The caregiver would not typically bring the child to a

ventral/ventral position. He/she seems minimally interested in providing genuine comfort.

3 = Moderately characteristic. This rating should be given to caregivers who are predominantly sensitive/responsive. The caregiver typically responds promptly to child distress, demands, and signals, but there is some time in which clear child signals do not receive a response or in which the response is somewhat delayed. Some of the caregiver's responses are mixed, i.e., some half-hearted or perfunctory, but the majority are full responses where the observer feels like "that was a good episode."

4 = Highly characteristic. This rating should be given to caregivers who are exceptionally sensitive and responsive to distress. The caregiver responds quickly and appropriately to the child's distress. If the child is upset, the caregiver takes time to soothe and calm the child. There may be proportionally few instances of ignoring and/or minimally responding to the distress, but overall most responses are prompt, appropriate, and effective.

9 = No opportunity to observe. No instances of child distress are observed.

SENSITIVITY/RESPONSIVENESS TO NONDISTRESS

This scale focuses on how the caregiver observes and responds to the child's social gestures, expressions, and signals. The key defining characteristic of sensitive interaction is that it is child centered. The sensitive caregiver is tuned to the child and manifests awareness of the child's needs, moods, interests, and capabilities, and allows this awareness to guide his/her interaction.

If the child initiates social gestures and expressions (looking at the caregiver, reaching toward the caregiver, waving, clapping hands, handing objects, directing speech to the caregiver), or makes demands, desires, or requests known (stretching arms to be picked up, reaching for toys the caregiver is holding), the sensitive caregiver responds appropriately, based on the child's cues.

If the child appears disengaged, the sensitive caregiver takes time to reengage the child in a manner that demonstrates sensitivity to the child's mood. When the child is bored or frustrated, the caregiver offers toys or other engaging opportunities. When the child is interested and involved with toys, the sensitive caregiver allows him/her time to independently explore them. During play, the sensitive caregiver provides one toy or game at a time and bases continuation on the child's response. How and what they play is geared to whether or not the child seems to be enjoying the activity. The caregiver

does not persist with an activity or toy that the child is obviously not enjoying. During feeding, the caregiver follows the child's signals (open mouth, reaching, etc.) as to when the child wishes more food and accepts refusals of food. At this age, the sensitive caregiver generally encourages self-feeding and thus facilitates autonomy and self-help skills.

A sensitive caregiver provides stimulation that is situationally appropriate. He/she provides the child with contingent vocal stimulation and acknowledges the child's interest, efforts, affect, and accomplishments.

Sensitive caregivers need not spend all the time engaged with the child, but the difference between them and the detached caregiver is that the sensitive caregiver seems to be actively taking an interest in the child's activities, as evidenced by comments, embellishments, or redirection when the child loses interest. It is at these times -- when the child loses interest or generally becomes aimless -- that the difference between the sensitive caregiver and the detached, understimulating caregiver is most easily seen; the detached caregiver does not respond, responds in a listless manner, or responds with developmentally inappropriate comments and behavior. The insensitive caregiver could also be overstimulating or intrusive and might continue in his/her attempts to engage the child even when the child is providing clues that he/she is seeking to end the interaction.

A sensitive interaction is well timed and paced to the child's responses, a function of its child-centered nature. Such an interaction appears to be "in sync." The caregiver paces games or toy presentation to keep the child engaged and interested, but also allows him/her to disengage if interest is lost and generally to shape the nature of the involvement. Sensitivity involves judging what is a pleasurable level of arousal for the child and helping the child to regulate arousal and affect. When the child loses interest, the sensitive caregiver switches to a new tactic, toy, or activity and observes the child's reaction, or reduces his/her involvement to allow the child a larger role in shaping the activity. In this way the sensitive caregiver can be distinguished from both an intrusive and a detached caregiver.

Markers of sensitivity include (a) acknowledging the child's affect; (b) contingent vocalizations by the caregiver; (c) facilitating the manipulation of an object or child movement; (d) appropriate attention focusing; (e) evidence of good timing paced to the child's interest and arousal level; (f) changing the pace when the child appears overstimulated or tired (e.g., turns away, is fussy); (g) picking up on the child's interest in toys or games; (h) shared positive affect; (i) encouragement of the child's efforts; (j) providing an appropriate level of stimulation when needed; (k) sitting on floor or low seat, at the child's level, to interact; and (l) removing from crib within a

few minutes after awakening, putting to bed when obviously tired, (m) not leaving a child for long periods unattended.

Thus, the sensitive caregiver demonstrates the ability to adapt her/his behavior to the child's mood and level of development. The caregiver neither over- nor understimulates. The caregiver knows when it is time to increase or reduce the amount of stimulation the child is experiencing. For example, the caregiver discontinues an activity that is beyond the child's capacity for response or introduces a new activity when the child appears bored.

Ratings on this scale should be based on both quality and quantity of caregiver behavior.

1 = Not at all characteristic. There are almost no signs of caregiver sensitivity. The caregiver may be either predominantly intrusive or detached. The caregiver rarely responds appropriately to the child's cues, and does not manifest an awareness of the child's needs. Interactions, if they occur at all, are characteristically ill timed or inappropriate.

2 = Minimally characteristic. This rating should be given to caregivers who display infrequent or weak sensitivity/responsivity. While the caregiver is sometimes sensitive, the balance is clearly in the direction of insensitivity.

3 = Moderately characteristic. This rating should be given to caregivers who are predominantly sensitive/responsive.

The caregiver demonstrates sensitivity in most interactions but may neglect to give a full response.

4 = Highly characteristic. This rating should be given to caregivers who are exceptionally sensitive and responsive to nondistress. Instances of insensitivity are rare and never striking. Interactions are characteristically well timed and appropriate.

INTRUSIVENESS

Intrusive, insensitive interaction is definitely adult-centered rather than child-centered. Prototypically, intrusive caregivers impose their agenda on the child despite signals that a different activity, level, or pace of interaction is needed. High arousal, vigorous physical interaction, or a rapid pace are not, by themselves, indicative of intrusive overstimulation -- if the child responds positively with sustained interest and is not engaging in defensive behaviors. Intrusiveness is apparent when the caregiver does not allow the child a "turn" or an opportunity to respond at his/her pace. Some intrusive caregivers persist in demonstrating toys to the child long after his/her interest has been gained and he/she obviously wants to manipulate the toy him/herself. These caregivers appear unable to relinquish control of the interaction in order to facilitate the child's exploration or regulation of the activity. Another example of controlling, intrusive behavior is displayed by caregivers

overwhelming the child with a rapid succession of toys or suggestions, not allowing him/her time to react to one before another occurs. Extreme intrusiveness can be seen as overcontrol to a point where the child's autonomy is at stake. A caregiver can be involved in play with the child without being highly intrusive, if the caregiver follows the child's interest, pace, and signals.

Intrusiveness can be displayed during routine care. During feeding, a nonintrusive caregiver will generally allow the child to attempt to feed him or herself, whereas an intrusive caregiver will push the child along, often taking over the feeding even when assistance is not needed or desired. The caregiver's assistance in feeding is not in itself a sign of intrusiveness if assistance is needed and the pace appears to match the child's desires.

Specific behaviors characterizing intrusive interactions include (a) failing to modulate behavior that the child turns from, defends against, or expresses negative affect to; (b) offering a continuous barrage of stimulation, food, or toys; (c) not allowing the child to influence the pace or focus of play, activities, interaction, or feeding; (d) taking away objects or food while the child still appears interested; (e) not allowing the child to handle toys he/she reaches for; (f) insisting that the child do something (play, eat, interact) in which he/she is

not interested; and (g) not allowing the child to make choices, (h) poking the child with toys, fingers, etc.

Caregiver actions which are clearly in the child's best interests, such as removing a child from danger, administering medicine, or putting an obviously tired child to bed, are not included in considerations of intrusiveness.

Ratings of intrusiveness must be evaluated from the perspective of the child.

1 = Not at all characteristic. This rating should be given to caregivers who display almost no signs of intrusive behavior.

2 = Minimally characteristic. This rating should be given to caregivers who display minimal intrusiveness. There is some evidence of intrusiveness, but it is not typical. The caregiver may initiate interactions with and offer suggestions to the child which occasionally are not welcomed. The caregiver sometimes continues his/her activity after the child engages in defensive behavior, but does not escalate the activity.

3 = Moderately characteristic. This rating should be given to caregivers who are often intrusive. Caregiver intrusiveness occurs with moderate frequency. Or, for caregivers who rarely interact, a substantial proportion of their interactions are intrusive.

4 = Highly characteristic. This caregiver's interactions with the child are consistently and typically intrusive. During

their interaction, the caregiver controls the interaction, allowing the child little self-direction in his/her activities. During the time that they are interacting, the caregiver allows the child little autonomy, and essentially negates the child's experience.

DETACHMENT/DISENGAGEMENT

The detached caregiver appears emotionally uninvolved or disengaged, and unaware of the child's needs for appropriate interaction to facilitate involvement with objects or people. This caregiver does not react contingently to the child's vocalizations or actions, and does not facilitate the child's explorations and developmental progressions through interpersonal support. Thus, there is little joining in the child's play, participating in "conversations" or even awareness of what the child is doing. Detached caregivers "miss" the child's looks to them or vocalizations to them, or other cues that call for caregiver attention and involvement. When they do interact, their timing is often out of synchrony with the child's affect and responses (although not with the overwhelming barrage of stimulation that intrusive caregivers present).

Simply allowing the child to play by him/herself is not necessarily a sure sign of detachment; this can be appropriate at times, such as when the child is playing happily or contentedly and the caregiver checks in with the child visually. The

detached/disengaged caregiver is passive, and lacks the emotional involvement that characterizes a sensitive caregiver. He/she appears uninterested in the child.

A caregiver receiving a high rating for detachment is considered to be insensitive. A low rating for detachment can reflect either sensitivity or intrusiveness.

Detachment can be marked by (a) the child being out of sight of the caregiver for extended periods, without the caregiver checking in on the child; (b) rarely making eye contact or rarely talking to the child; (c) not responding to the child's vocalizations, smiles, or cues for engagement or attention; (d) being unaware of the child's capabilities and appropriate activities; (e) cleaning the child, rocking, diapering, or providing food in a mechanical, detached, distant way without social interaction; (f) ignoring or being apparently unaware of the interesting things the child does; and (g) not calling the child by his or her name. Some detached caregivers place an overemphasis on the physical setting or other adults (e.g., visiting with other caregivers, filling out forms, straightening the room) instead of attending to the child.

This scale contains both qualitative and quantitative components. A caregiver who interacts consistently with the child but does so in a perfunctory or indifferent manner with little or no emotional involvement would be rated high on detachment.

1 = Not at all characteristic. This rating should be given to caregivers who display almost no signs of detachment or underinvolvement. When interacting with the child, the caregiver is clearly emotionally involved. These caregivers can be sensitive or intrusive.

2 = Minimally characteristic. This rating should be given to caregivers who display minimal detachment. While the caregiver is sometimes noninvolved, he/she is clearly more involved than not.

3 = Moderately characteristic. This rating should be given to caregivers who are mostly detached. The caregiver is relatively more noninvolved than involved.

4 = Highly characteristic. The child is without caregiver attention almost all of the time, even when the caregiver is within a suitable distance for interacting. In the minimal instances of involvement, the caregiver's behaviors are simple, mechanical, stereotyped, repetitive, and perfunctory. The caregiver is clearly not emotionally involved with the child, and appears to be "just going through the motions."

STIMULATION OF DEVELOPMENT

This scale measures the degree to which the caregiver tries to foster the child's development. A stimulating caregiver may take advantage of even simple activities (like washing hands and diapering) to stimulate development, and will consistently engage in a variety of activities that can facilitate learning. The caregiver will make deliberate attempts to encourage the child's development, achievement, and learning.

Behaviors characterizing stimulation include (a) attempting to focus the child on an object or task; (b) focusing the child's attention on the perceptual qualities (sounds, colors, movement, etc.) of objects; (c) verbally responding to or expanding on the child's verbalizations or vocalizations; and (d) encouraging the child to actively participate in activities. However, caregivers who simply focus or encourage a child should not be given the highest scores. Higher scores should be reserved for those caregivers who (a) describe or label toys, objects, and activities, (b) or demonstrate how things work; (c) stimulate the child's verbalizations or vocalizations and expand on them; (d) read or recite to the child; (e) encourage and reinforce the child's attempts at mastery, or challenge the child to try something new; (f) present activities in an organized sequence of steps; (g) teach the child or give him/her an opportunity to experiment with materials that illustrate or teach concepts; (h) ask questions that require problem solving; (i) label and

interpret the child's experiences, (e.g. "You think that's funny"); and so on.

Activities involving strictly physical stimulation such as rough and tumble play, bouncing, and tickling are not considered as stimulating development per se, but it is possible for a caregiver to provide stimulation in these contexts if the caregiver expands on these experiences with verbal labels. The encouragement of new physical skills such as hopping, would be considered stimulation. This scale does not measure those activities that are only social (smiling) or caretaking (soothing), but stimulation can occur in these contexts as well.

Stimulation must involve effortful interaction with the child in the contexts described above. Simply providing a child toys is not to be considered stimulating.

The focus of this scale is on the amount and quality of activities that may ultimately enhance perceptual, cognitive, linguistic, and physical development. All qualitative judgments must be considered in relation to the quantity of stimulation provided by the caregiver: How many of the available opportunities for stimulation were taken advantage of? A rating of 1 should be given to those caregivers who provide almost no stimulation of development. If a caregiver spends a brief portion of the 44 minute observation in very cognitively stimulating interactions with a child and provides that child with no stimulation for the remainder of the time, he/she would

receive a rating of 2. A caregiver might also receive a 2 for several instances of lower level stimulation. A rating of 4 should be given to those caregivers who work at providing exceptionally advantageous stimulation in terms of language and object manipulation. This is not a rating of the sensitivity with which the cognitive stimulation is provided but purely the quantity and variety of cognitive stimulation as described above.

1 = Not at all characteristic. The caregiver makes almost no attempts to teach the child anything or provide any stimulation. He/she may provide routine care but does not use it as an opportunity for learning. The caregiver may ignore the child's activities or interact perfunctorily, providing no stimulation.

2 = Minimally characteristic. This rating should be given to caregivers who provide infrequent or weak stimulation. The caregiver's conscious and purposeful attempts to engage the child in development-fostering experiences are limited. He/she may label or demonstrate materials, but does so perfunctorily and/or with minimal elaboration.

3 = Moderately characteristic. This rating should be given to caregivers who provide adequate stimulation but could reasonably be expected to provide more and higher-quality stimulation. The caregiver does make some effort to provide stimulation, but does not consistently take advantage of opportunities to do so. Stimulation is not the main agenda. The

caregiver may find some new ways to engage the child with toys, for example, but these ways are limited in number. Actions are likely to be simply repeated rather than thoughtfully varied. Caregivers who provide a rich linguistic environment but do not demonstrate the potential of toys or objects would receive this rating.

4 = Very characteristic. This rating should be given to the caregiver who is consistently stimulating and takes advantage of many activities as opportunities for stimulation. The caregiver provides frequent stimulation through "lessons," explanations, activities, or toys. Teaching or fostering development is a primary intent of the caregiver's frequent interactions with the child. The caregiver thoughtfully varies and elaborates on these activities, providing numerous opportunities which are exceptionally advantageous to the child. He/she provides rich stimulation in terms of language, and embellishment of the potential of the physical world.

POSITIVE REGARD FOR THE CHILD

This scale rates the caregiver's positive feelings toward the child, expressed during interaction with him/her. Positive feelings are shown by (a) speaking in a warm tone of voice; (b) hugging or other expressions of physical affection; (c) smiling; (d) laughing with the child; (e) enthusiasm about the child; (f) praising the child; and (g) general enjoyment of the child.

Positive regard is also evident when the caregiver listens, watches attentively, looks into the child's face when talking to him/her, has affectionate physical contact, and is playful.

Ratings on this scale are based on both quality and quantity of positive regard.

1 = Not at all characteristic. This rating should be given to caregivers who display almost no positive regard. This rating can also be used for positive expressions (laughing, smiling) that appear to be inappropriate to the situation or an inaccurate reflection of the caregiver's feelings. The caregiver may be expressionless or flat, or negative.

2 = Minimally characteristic. This rating should be given to caregivers who display infrequent or weak signals of positive regard. The intensity and/or frequency of behavioral indicators are very low.

3 = Moderately characteristic. This rating should be given to caregivers who typically display positive regard. More frequent and intense positive affect is shown than in the 2 rating, but the caregiver is not as consistently positive as those scored as a 4.

4 = Very characteristic. This rating should be given to caregivers who are exceptionally positive, in terms of facial and vocal expressiveness, and behavior. Affect is positive and spontaneous. The caregiver shows a range of expressions and

behaviors which are all clearly positive. He/she clearly "delights" in the child.

NEGATIVE REGARD FOR THE CHILD

This scale rates the caregiver's negative regard for the child. Both frequency and intensity of negative affect toward the child are considered. Some markers of negative regard include (a) disapproval; (b) tense body; (c) negative voice when correcting; (d) abruptness; (e) tense facial muscles and strained expression; (f) harshness; (g) threatening the child or punishing without explanation; and (h) excessive roughness in wiping the child's face or changing his/her diapers.

Ratings on this scale are composed of both qualitative and quantitative evaluations. The amount and intensity of negative affect exhibited is evaluated in relation to the duration of the observation period.

1 = Not at all characteristic. This rating should be given to caregivers who do not display negative regard for the child either in words or in expressions. No evidence of anger, distrust, frustration, impatience, disgust, general dislike, or other indicators of negative regard is observed in the caregiver's face or voice. The caregiver may be expressionless or flat, or positive.

2 = Minimally characteristic. This rating should be given to caregivers who display minimal negative regard. There is some evidence of low-intensity negative regard.

3 = Moderately characteristic. This rating should be given to caregivers who regularly display negative regard. Multiple instances of low-intensity negative regard or some evidence of more-intense negative regard is observed.

4 = Highly characteristic. This rating should be given to caregivers who are extremely negative. Feelings of negative regard are expressed persistently at moderate levels or at times strongly. The overriding affect influencing the caregiver-child interactions is negative.

FLATNESS OF AFFECT

This scale measures how animated the caregiver is with the focal child and others in the room. Flat affect may reflect boredom, depression, fatigue, or distraction. Flatness is exhibited by blank, impassive facial expression and flat tone in vocal expression. It is marked by a lack of animation. If the caregiver is watching the child with interest (eyes "bright"), it is a sign that the caregiver's affect is not flat. This scale assesses the caregiver's overall demeanor, not just animation with the target child.

1 = Not at all characteristic. This rating should be given to caregivers who exhibit almost no flatness. The caregiver's demeanor and behavior are consistently animated.

2 = Minimally characteristic. This rating should be given to caregivers who exhibit some flatness. The caregiver is usually animated, but there are occasions when facial expression and/or voice is blank and impassive.

3 = Moderately characteristic. This rating should be given to caregivers who are mostly flat. Some periods of animation alternate with more clear periods of flatness than observed for a score of 2. Flat affect predominates.

4 = Highly characteristic. This rating should be given to caregivers who are consistently flat. There is consistent absence of animation.

b. Child ratings

POSITIVE MOOD

This scale assesses the extent to which the child is satisfied, content, and pleased with the situation overall. Measures of child positive affect include smiles, laughter, and positive tone of voice, as well as enthusiasm expressed with arms, legs, and body tone. Lack of positive affect may be manifested by a neutrality or negative mood.

Ratings on this scale should be based on quality and quantity of behavior. Attempt to balance both the intensity of

the child's positive affect and the relative amount of time positive behavior is shown. A rating of 1 should be given to those children who exhibit either neutral affect or strong negative affect. If a child spends a very brief portion of the total 44 minutes exhibiting moderately high positive affect (e.g. some smiles), he/she would receive a rating of 2. A child might also receive a 2 rating for 44 continuous minutes of weak positive affect (i.e., contentment/pleasant expression). A rating of 3 is given if the child is regularly pleasant, with some strong positive affect (laughter, frequent smiles). A rating of 4 should be given to those children who regularly display high-intensity positive affect.

1 = Not at all characteristic. This rating should be given to children who display almost no signs of positive mood. No positive mood indicators are displayed.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak positive affect. The child may show brief instances of strong or moderately strong positive affect, or the child may be characteristically pleasant, content, or satisfied throughout the observation period, without exhibiting any strong indicators of positive mood.

3 = Moderately characteristic. This rating should be given to children who frequently display positive affect. The child exhibits several instances of strong positive affect (expresses

enthusiasm, playfulness, smiling and laughter) and is often pleasant.

4 = Highly characteristic. This rating should be given to children who are exceptionally positive, in terms of physical and vocal expressiveness. The child displays multiple instances of strong positive affect and is characteristically "pleasant" for most of the remainder of the observation period. The child should truly "radiate" or "sparkle" much of the time.

NEGATIVE MOOD

This scale assesses the extent to which the child cries, fusses, frowns, tenses body while crying, or otherwise expresses his/her discontentment. Lack of negative affect may be manifested as either strong positive affect or contentment.

Ratings on this scale should be based on both qualitative and quantitative assessments.

1 = Not at all characteristic. This rating should be given to children who display no negative affect. There are no signs of strong (intense crying, body stiffening) or periods of weak (e.g. fussing) negative affect from the child during the observation period. There may be one very mild instance of negative mood.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak negative affect. The child displays brief instances of mild negative affect.

3 = Moderately characteristic. This rating should be given to children who display stronger and/or more frequent negative affect. The child displays one or two instances of strong negative affect or is moderately discontented ("fussy") throughout much of the observation period.

4 = Highly characteristic. This rating should be given to children who display high levels of negative affect. The child displays several instances of strong negative affect during the observation period and appears to be rarely contented.

ACTIVITY LEVEL

This scale assesses how motorically active the child is during the observation. The rating should take into account these aspects of motor activity: speed (moving fast, whether walking, crawling, or squirming); frequency (spending a lot of time in high energy activities); intensity (how energetic the activity); involvement (tendency to engage in high-energy games and gross motor activities over small motor activities); and a negative reaction to enforced nonactivity (reacting with restlessness).

1 = Not at all active. This rating should be given to children who are noticeably low key, passive, inactive, lethargic. The child typically stays in one place.

2 = Minimally active. This rating should be given to children who are minimally active. The child exhibits some activity.

3 = Moderately active. This rating should be given to those children who are predominantly active. Activity occurs frequently, and some or all movements are of high intensity.

4 = Highly active. This rating should be given to children who are extremely active. The child is almost constantly moving some body part; something is moving most of the time. The child prefers active games and activities to nonactive ones and protests or squirms if held in one place.

SOCIABILITY (WITH PEERS)

This scale assesses the degree to which the child actively participates in his/her social world with peers. Behaviors which can be considered to indicate sociability include vocalizing to, smiling at, waving to, sharing toys with, crawling or walking to, and touching peers. These behaviors may be initiated by the child, or be responses to peers' signals or initiations.

Initiative and responsive behaviors must be perceived to have a positive social interactive intent.

Ratings on this scale should be based on both quality and quantity of behaviors.

1 = Not at all characteristic. This rating should be given to children who display almost no sociability. There are no social initiations by the child or responsiveness to peers' overtures. The child seems oblivious to peers.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak social behavior with peers. Social initiations or responses by the child occur, but they are very infrequent or ambiguous. The child is usually engaged in his/her own activity and seems to generally be uninterested in the other children. Peers must typically be persistent to gain the child's social interest, which tends to be brief and of low intensity (e.g., a look).

3 = Moderately characteristic. This rating should be given to children who display frequent social behavior with their peers. The child initiates and/or responds, but the intensity and frequency of the child's behavior is less than a 4.

4 = Highly characteristic. This rating should be given to children who are very sociable. The child initiates and/or responds very frequently, using a variety of behaviors. There are multiple instances of the child directing clear, positive signals to other children and/or responding to others' initiations.

9 = No opportunity to observe. No peers were present.

SUSTAINED ATTENTION WITH OBJECTS AND ACTIVITIES

This scale assesses children's sustained involvement with the world of objects and other activities that are not predominantly social. The child's attention does not jump from one thing to another quickly. The child spends more than a minimal amount of time focusing on the object or activity he/she is engaged in. When playing with an object or engaged with an activity the child really "focuses in." The uninvolved child may appear apathetic, bored, distracted, distressed, or aimless.

This scale addresses nonsocial attention. Focus on or engagement with caregivers or peers is not to be included.

Sustained attention includes playing with a single toy or playing with thematically related toys. For example, playing with a brush and a doll or a cup and a saucer. Playing among unrelated toys, even if they are all in front of him on the floor, switching from one toy to another, is not displaying sustained attention.

The focus of this scale is primarily quantitative. Ratings are based primarily on the duration of interactions with objects or engagement with an activity, and the overall amount of time spent in these.

1 = Not characteristic. This rating should be given to children who display almost no sustained attention. The child moves from one thing to another in a nonsystematic way, without seeming to focus on what the objects have to offer.

2 = Minimally characteristic. This rating should be given to children who can sustain attention for only brief periods or for only a limited proportion of the observation period.

3 = Moderately characteristic. This rating should be given to the child who spends more than the minimal amount of time involved in interactions with things, but could reasonably be expected to attend longer.

4 = Highly characteristic. This rating should be given to the child who is clearly involved, interested, and focused most of the time. When the child is playing with objects he/she is interested in playing with them and is engaged for extended periods of time.

POSITIVE ENGAGEMENT WITH CAREGIVER

This scale assesses the extent to which the child is socially connected to the caregiver. Behaviors indicative of engagement include (a) positive responding to the caregiver's initiation of a play activity (attending to the caregiver's suggestions or demonstrations of an activity, and following her lead by adopting that activity or incorporating an offered object into ongoing play); (b) initiating interaction that includes the caregiver (by offering/showing an object, requesting help, etc.); (c) positioning/orienting body toward the caregiver, and (d) sustained attention during interaction or play with the

caregiver. Behaviors indicative of disengagement include (a) active rejection of caregiver's play overtures (by pushing offered objects away, ignoring the caregiver); (b) engaging in self-occupied play that excludes the caregiver; (c) positioning/orienting body away from the caregiver. A lack of engagement can also be seen when caregivers are highly detached and the child does not initiate interaction. Ratings on this scale should be based on both quality and quantity of behavior. The rating is made for the same caregiver(s) as were rated on the caregiver scale.

1 = Not at all characteristic. This rating should be given to children who display almost no engagement with the caregiver. Children given this rating seem clearly disconnected and disengaged. They actively reject or ignore the caregiver, although they may look at her briefly when she attempts an initiation.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak engagement. These children are somewhat responsive to caregiver, but not in a sustained way. Brief periods of engagement may occur. Play appears self-occupied -- typically it excludes the caregiver, although active rejection also may be present.

3 = Moderately characteristic. This rating should be given to children who are more engaged with the caregiver than not. The

child initiates and/or responds, but the intensity and/or frequency of the child's behavior is less than a 4.

4 = Highly characteristic. This rating should be given to children who are very engaged with the caregiver. The child has a high frequency of initiations that include the caregiver and/or positive responses to the caregiver's initiations. Sustained play with the caregiver is observed.

6. Post Observation Interview with Caregiver(s)

At the conclusion of each day of observation, the observer needs to ask one of the observed caregivers the "typical visit" questions in the Post Visit Interview. Only complete one per day. First, record the temporary ID number of the caregiver who is being interviewed. Then, sitting side-by-side with him/her, work through the questions. This should take about 3 minutes. Thus, at the end of the two days of observation, you will have 2 of these completed interviews.

7. End of Visit Scales

At the conclusion of each day of observation, complete the End-of-Visit Scales.

Question 7.

Record your best assessment of the amount of time CHILD was outdoors during your visit.

Question 8.

Record your best assessment of the amount of smoking you observed during this visit.

Definitions:

0 = None

1 = A little - Observed only one cigarette smoked in outdoor setting.

2 = Some - Observed one cigarette smoked near child's face (within 3 feet) or several cigarettes smoked at a distance (>3 feet from face).

3 = Moderate - More than 1 cigarette smoked near Child/s face.

4 = A lot - Air is smoky during most of the visit.

OVERALL POSITIVE RELATIONSHIP OF CAREGIVER WITH TARGET CHILD

(LOVE/ATTACHMENT) Complete this rating for the caregivers for whom you made Qualitative Ratings.

Caregiver is positive, affectionate to child -- to target child in particular, not just any child -- and child uses

caregiver as source of comfort, someone with whom to share experiences.

There is a loving relationship between the two. "Love" is difficult to observe; it must be inferred on the basis of everything that occurs over the course of the observation, including mutual attentiveness, closeness of physical contact, tenderness, responsiveness, and care. The frequency of mutual positive regard, the caregiver's patience and sensitivity, and the intensity and tenderness with which all of these are expressed are all involved. The relationship may be expressed in exuberant actions such as snuggling and cooing or gentle ones such as quiet reassurance or warm holding and whispering. It is not pride, as in showing off the child to others, or the habitual smile used as a defense against apathy; rather, it is an spontaneous expression of strong (mutual) attachment.

1 = no evidence of a special loving relationship; caregiver never singles out the target child for special attention or affection; child indicates no preference for caregiver

2 = hints that a positive relationship may be developing, some evidence of positive feeling, but minimal

3 = definitely is a relationship but it is not strongly or uniformly positive; it may be ambivalent

4 = clear evidence of a strong loving relationship between caregiver and child

9 = inadequate opportunity to observe/rate -- impossible to judge the nature of the relationship between the caregiver and child because they interacted so little (because of extenuating circumstances, not neglect)

CHILD-CENTEREDNESS OF CARE

1 = care is inadequate or barely adequate; what matters is the convenience of the staff. No adult is devoting full attention to making the lives of the children better.

2 = care is adult centered; infants may receive adequate care, be responded to promptly, but this is largely in the service of adult goals. Care is never hostile, rejecting, or inappropriate, but it is also not marked by any special gentleness, respect, appreciation, interest in particular children, etc.

3 = care is somewhat/sometimes child centered; sometimes or some children get good care.

4 = care is consistently child centered. When adults talk to each other it is about the children. Children are talked about with pride, wonder, appreciation, and concern. When adults care for children, it is with the goal of maintaining or improving their comfort, contentment, interest, etc., rather than with making the adult's experience more interesting. There is marked gentleness in handling, marked pride and affection in tone of voice, marked concern with children's well-being, and clear,

concerted efforts to provide children with nurturing, stimulating experiences. This scale refers to the caregivers' approach to all children, in general, not just to the target child. All the children get good care.

CODER'S OVERALL IMPRESSION OF CHILD CARE

This is an overall global rating of the child care observed during the visit, ranging from terrible to excellent. It should be based on the quality of the child's experience, the caregiving provided, and the general ambiance of the setting (including what is happening to other children during your visit). It is compared to your idea of "ideal" care.

MALADAPTIVE BEHAVIOR CHECKLIST

Code yes or no to each item indicating whether you saw any of the caregiver or child behaviors as described at any time during your visit. Other refers to any other adult present during the visit. Note that only smoking behaviors are recorded in this column. Unless the item specifies "target child," these items for the caregiver apply to interaction with the target child or any other child in the setting. Prolonged blank stare = catatonic. Unconsolability = cannot be consoled even though the caregiver tries everything.

HOW TYPICAL WAS THE DAY

The purpose of these scales is to try to ascertain whether the day was markedly atypical. Use your best judgment to rate how ill at ease each caregiver was. Indicate your impressions of how much the target child tried to interact with you.

For how much the child interacted with you, code behavior only after the first 10 minutes of the observation.

F. Profile Observation Procedures

Two instruments are being used to provide a comprehensive assessment of the quality of the child's child-care arrangement. The Assessment Profile for Early Childhood Programs (Abbott-Shim & Sibley, 1987) is used for all center-based arrangements; The Assessment Profile for Family Day Care (Sibley & Abbott-Shim, 1987) is used for all other arrangements, ranging from family day care homes, to relative care, to care in the child's own home (all settings that also serve as residences). There are a few items on this version of the Profile that will not be completed for arrangements in which the target child or the target child and his/her siblings are the only children in care (i.e. Item 12 for Safety and Health and all Individualizing items). If the caregiver has any of his/her own children at home at the same time, then code these items. These items are noted on the coding form. In addition, EXCLUDE the entire Profile when assessing child-care arrangements in which the child is cared for at the

mother's workplace when this workplace is not a child-care center/home.

Note that this is a room-level or group level (if the class is divided into different groups according to age etc.) assessment of quality. You need to rate these items considering all the children who receive care as part of the target child's group, not just the target child. Think of these items as measures of child's child-care environment, not his/her direct caretaking.

If you do not observe what you need to observe in order to complete an item (no diapering, no cooking, etc.) ASK the caregiver about the item and code response in the "R" column.

1. Overview of the Profile Instruments

The Assessment Profile for Early Childhood Centers is an observational measure that provides a comprehensive, systematic assessment of center quality. The Profile is organized in a series of levels of increasing specificity. The first level is broad and include four program Components: Administration, Preschool, Infant, and School-Age. The 15-month assessment uses only the Infant Component. The next level is more specific and focuses on a number of Dimensions within each Component, e.g., Safety and Health. Each Dimension contains a set of Standards. Standards are general statements that represent values and expectations. Each Standard is supported with specific Criteria.

Criteria are concrete, observable procedures, behaviors, and records that exemplify values and expectations.

Observations are recorded for Criteria as either "yes" (observed) or "no" (not observed). To obtain the most accurate information, three methods of data collection are used: observation (O) of classrooms, review of documentation (D), and report (R) based on conferences with directors and staff. "Observation" indicates that you actually observed the physical characteristics and interactions. "Documentation" reflects that the evidence of the physical characteristic and/or interaction was obtained through a review of a variety of records. "Report" means that the characteristic was reported to be present in conferences with program staff and teachers. On the data code sheet, the observer has 6 response choices: Yes - O, R, D and No - O, R, D. Only one should be recorded per item to indicate simultaneously whether the criteria is a "yes" or "no" and how this information was obtained.

The Assessment Profile for Family Day Care (Form 11R) is the counterpart to the Assessment Profile for Early Childhood Centers, adapted to suit the circumstances of home-based care. As with the Center Profile (Form 11S), the Profile for Family Day Care is organized in a series of levels of increasing specificity. Each Dimension (e.g., Learning Environment) contains a set of Standards. Standards are general statements that represent values and expectations. For example: "The

arrangement of physical space encourages the child's independent exploration." Each Standard is supported with specific Criteria. Criteria are concrete, observable procedures, behaviors, and records that exemplify the values and expectations. For example: "Toys for child use are accessible so that children can reach them." Observations are recorded using dichotomous yes/no ratings, and the three methods of data collection -- Observation, Documentation, and Report -- are used.

2. Reduction of Profile Items

Due to time constraints, it was necessary to reduce the number of items on the Profile for the NICHD Study of Early Child Care. An initial decision was made to use three of the five Dimensions from the Assessment Profile for Early Childhood Programs: Safety and Health, Learning Environment, and Individualizing. Based on data provided by Martha Abbott-Shim, from 40 center-based infant classrooms, on which complete Profile data had been collected, part-whole correlations were exemplified for each of these three Dimensions to determine the items with the highest correlations to the total scale score. Items with correlations of .40 or higher were retained and an alpha was run on the final, reduced Dimension. These were: Safety and Health = .70 (8 items), Learning Environment = .82 (10 items), and Individualizing = .85 (12 items). The Assessment Profile for Family Day Care was then reduced by cross-walking each item on

the reduced version of the Center Profile to a comparable item (or set of items) on the Profile for Family Day Care. No data were available for checking the alphas on these reduced Dimensions. Thus, the reduced Profile for Family Day Care contains 27 items for the Safety and Health Dimension, 8 items for the Learning Environment Dimension, and 6 items for the Individualizing Dimension.

ADDITION OF PHYSICAL ENVIRONMENT AND ADULT NEEDS SUBSCALES

Two dimensions of quality not included in the Profile were added. These are items regarding the Physical Environment (adapted from Wachs, 1986), and the Adults Needs subscale from the Early Childhood Environment Rating Scale (Harms & Clifford, 1980). The Adults Needs subscale was added to the Center Version of the Profile and not the Home Version.

3. Conducting the Profile

Whenever possible, observation is the recommended information source. Ideally, to obtain an accurate representation of the activities and interactions, you should schedule observations to include a variety of events such as meals, learning activities, outdoor play, naps, and if possible, arrivals and departures of the children. After your ORCE observations, ask the caregiver if there are any other rooms where child is cared for. Ask to take a quick tour.

Focus your observations on what the target child experiences in his/her classroom. Before ending observations, review all Criteria designated with an "O" for Methods, to be sure that a response has been recorded.

Documentation involves a review of a variety of records that support child-care services. The primary purpose for reviewing documentation is to verify specific child-care practices. For example, written procedures for emergencies

verify that the Provider is prepared to handle emergency situations; a child-care handbook verifies that policies have been established and are available in a form that supports communication with parents.

Observations and a review of documents provide concrete evidence of the Provider's practices and procedures. However, there are many activities and procedures that occur and support child care which are not readily observable or represented in tangible documents. Consequently, the Profile also includes criteria which involve the Provider's reports. These Criteria are designated with an "R" under Methods and will involve information the Provider will be able to share to clarify observations, documentation, and procedures.

When items have more than one method designated, observation is the preferred form of data collection. However, on occasion, it is not possible to observe a Criterion. For example, it may not be possible to observe outdoor play because of inclement weather. These instances should be the exception rather than the rule and the information should be gathered through discussion with the Provider. In these instances, record your response under "R".

A yes/no column with O, R, and D response choices indicated is provided to record observations. All criteria are checked O, R, or D under "yes" if positively observed and O, R, or D under "no" if not observed, not observed to occur with consistency, or

reported as "does not occur." A choice between "yes" and "no" is required for all Criteria. Some Criteria specify two conditions and both conditions are required to exist to score "Yes." This does not apply to items with "and/or" statements.

We recommend that the Profile observations be completed after the ORCE on the first day's visit, saving any items requiring documentation or reporting to be completed on Day 2, during the staff interviews. In general, the child's classroom teacher -- in the case of centers -- will provide the best source for reported and documented data. On occasion, however, some data may need to be obtained from the center director. Do not change ratings made on Day 1 on Day 2, unless you see a violation of a Safety and Health item. In other words, if you have coded a "learning environment" item on Day 1, and see something on Day 2 that leads you to a different conclusion, do NOT change your code. It is only in cases of safety and health violations that you are allowed to change codes. Put the date of the FIRST visit on the cover sheet.

4. Clarification of Items

a. Assessment Profile for Centers

SAFETY & HEALTH

For all Safety & Health items, if one example of an unsafe or unhealthy practice is observed then record the item "NO." One violation is cause for coding "NO." Only one hazard need be

present for the item for a "NO" code, unlike the "dominant mode" criterion on the other items. Take into account how mobile the children are, and rate the environment according to all children who are using it. When in doubt, code an item as unsafe or unhealthy.

1. Hazards are any conditions that present potential danger or harm to a child: poisonous plants; breakable items at low level, open stairs. Code for hazards present, not for anticipated hazards (e.g., code heaters if they are on and hot at the time of your visit).

2. High chairs must have safety straps that wrap about the child's stomach and between the legs to prevent slipping off the high chair, under the tray. A tray is not sufficient to safely secure the child. Check that there is a strap for waist and for between the child's legs -- and that these are used. If you don't see the high chairs in use during your visit but the chairs with straps are available, code "YES." If the chairs with straps are available but the straps aren't used while the children are in the chairs, code "NO."

3. Cribs are safe - Mattress fits snugly within crib; mattress is low in the crib with at least 22 inches (about an arm's length) from the top of the railing to the mattress; side rails are raised and secured; distance between crib slats is no greater than 2 3/8 inches (about the width of three fingers) apart; no hanging crib toys are within reach of infant; no large

toys which may become steps are in the crib. If crib is shared but there is no overlap between children's attendance and separate, labelled sheets are used, code "yes."

4. Written emergency procedures and an evacuation diagram should be posted for all pertinent hazards, as determined by the local geography or region of the country. For example, evacuation procedures for flooding may not be a presenting hazard but earthquakes may be. In this case earthquake evacuation procedures should be posted but flooding evaluation procedures should not. Evacuation procedures should include specific directions for relocating non-mobile infants. A simple diagram is not sufficient; a written procedure (such as: windows should be opened [or closed], take the roster, check specific areas of the classroom for children, close the door, etc.) for relocating children is posted. The diagram and the written procedures are intended for adult reference. Written procedures should include a narrative description for adults, and should include what is to be done with nonmobile infants. These instructions and diagram should be accessible, preferably within the room, or at least "geographically sensible."

5. Each disposable or paper towel is used exclusively for one child or by one adult to prevent the spread of germs. Individual cloth towels are OK. If they are available but you don't get a chance to see them used, code "YES." If they are available but you see them being used improperly, code "NO."

6. Plastic, rubber and cloth toys that are available for exchange are washed daily to disinfect. Washing can be done with disinfectant solution, soap and water, or in a dishwasher. Equipment, such as highchairs, walkers, swings, etc., is also washed daily. Disinfectant solution (1/4 cup bleach to 1 gallon of water) or other medically approved disinfectants are used. If a bleach and water solution is used, this solution must be mixed daily.

7. Diaper changing surface is not used for other purposes such as storing toys/materials, preparing food. This surface is not contiguous to food preparation and eating tables or highchairs. "Away from food prep area" means noncontiguous with food prep area. "Used exclusively for diapering" means just that; no storage on diapering surface for non-diapering supplies, not even temporarily. It is not considered healthy to diaper two children at once or to disinfect only the portion of the surface used for the child after using it. If the child is changed on a fresh piece of paper, this is OK as long as the urine would not soak through to the surface underneath.

8. There must be written descriptions of symptoms of common infant illnesses and physical and sexual abuse plus written program guidelines for how to deal with them. You should ask to see these materials. They must be accessible to the teacher when he/she needs them -- ideally within the room -- the issue of proximity is important here. It is not necessary that

this information be posted. Teachers must have ready access to this information; it may be in a classroom file or in the Director's office. Program guidelines refer to the program policies and procedures which include instructions for when and how to provide treatment, or notification of parents or isolation, etc. If a caregiver has received these guidelines, knows they are available in the director's office, but does not know where they are in her own room, you may code "yes."

Symptoms of common illnesses: Colds - runny nose, congestion, fever (oral 100°F, rectal 100.5°F), warm to the touch, chills, rapid breathing, flushed face; Diarrhea - soft or liquid bowel movements twice a day or more, abnormal cramps; Chicken pox - mild fever, tired, headache, itchy rash that changes from red spots to blisters and forms scabs; Bronchiolitis - rapid shallow breathing, wheezing, fever, cough, loss of appetite; Measles - low fever, mild runny nose, swollen glands in the back of the neck and behind ears, raised spots, joint pain and swelling; Mumps - swelling of salivary gland located in front of the earlobes, fever, loss of appetite, painful swallowing and chewing; Diaper rash - red patches with tiny pimples on skin areas covered by the diaper; Colic - infant may act hungry but cry part way through feeding, draws legs up to body and clenches fists; Earache - pain in the ear, rubbing and tugging at ear, inability to sleep, ear discharge, runny nose, congestion, fever.

Symptoms of physical and sexual abuse: Physical abuse - bruises, burns, welts; anxiety and fear of failure to such an extreme that child will not participate in activities; extreme aggression, particularly with brushes, brooms, rulers, tree branches; ducking or wincing at sudden adults moves; Sexual abuse - extreme changes in behavior such as loss of appetite; nightmares, roaming the house at night and fear of the dark; torn and stained underwear; vaginal infections or discharge or venereal disease; vaginal or rectal bleeding, pain, itching, swollen genitals; mature interest or knowledge of sexual behavior, expressing affection in ways unusual for a child of that age; fear of a particular person or an intense response to being taken to or left alone in a particular place; extreme aggressive or disruptive behavior or withdrawal.

LEARNING ENVIRONMENT

Here you will code according to the "dominant mode," and you will have to judge whether the dominant mode of the setting fulfills the item requirements.

1. Physical boundaries are barriers that separate the play space from other classroom areas (such as sleeping, feeding, diapering, etc.) Physical boundaries include walls, shelves, bolsters, etc. A physical boundary is something a child cannot crawl through. A table would not suffice. Walls, shelves, bolsters, etc. would.

2. Containers can be plastic baskets or boxes and should be of a size from which the child can manage to obtain a toy or replace a toy. Shelves and containers should be at a level that is reachable to the child so as to encourage child exploration. These indicate containers that the child has access to and can manage.

3. Designated floor space is provided for child play and creeping and protected from routine traffic paths of adults and their street shoes. The area must be protected from traffic patterns and street shoes -- even other children's shoes. The keywords for this item are nonmobile and creeping infants.

4. Materials that encourage large muscle exploration are readily approachable for children. There should be three different types of materials. "Types" means different categories of toys. Three sizes of balls are all still balls, and therefore represent only one type.

5. Materials that encourage musical exploration are readily approachable for children. There should be three different types (e.g., 3 different different tape cassettes would represent 1 type of material). Must be accessible without assistance from caregivers. Both a rattle and an overturned pan or pot qualify as musical instruments. Music being played (tapes, records) can count as a third music material even though it is not accessible to the child. A radio left playing constantly would not be a considered a musical material.

6. A special activity is a pre-planned activity that offers the children a novel experience that would not occur on a routine basis. Use "R" (report) if you don't observe and to find out how often activities occur.

7. This system of toy rotation removes toys that children have lost interest in and introduces additional toys that may have been stored or that are new. The emphasis of this item is the existence of a system or strategies to maintain infant interest. Sample queries: "How do you keep the children from getting bored?" "What do you do when the kids get bored?" "Do the kids get tired of the toys? How do you keep them interested?" "Do you have any system for keeping the kids interested in the toys?" Monthly rotation of toys is not enough.

8. Just consider availability, not necessarily use. There does not need to be enough for all the children. A backpack counts.

9. Three items minimum. If you are observing in the winter, ask if there is outdoor equipment and what it is.

10. Toys and materials are exploratory and portable items for children's use. These are items available for use outdoors. Must be five items. These items should be accessible/available during your visit. Do not take the provider's word that he/she has the items; you need to see them. It is okay if he/she rotates the 5 items so that only 2 or 3 are out at a given time.

The pieces of equipment may not be in use at the time (if the time is in the winter in Wisconsin.)

INDIVIDUALIZING:

Again, code for "dominant mode."

1. Cubbies and containers may be baskets, boxes, bins, tote/diaper bags, or shelf-like structures with individual compartments. Can count shelf and hook. Can count totes or diaper bags.

2. Self-explanatory.

3. If more than one child uses a crib, they must be scheduled to be present at different times of the day/evening. Both children's names should appear on the crib along with the hours each child will be in care. Crib must be labeled with name and schedule. Sheets should also be labelled. Could be a named mat or cot.

4. A teacher who is assigned as a primary caretaker assumes a major portion of the responsibility for the routine care and record keeping for a specific child. Other teachers may be engaged with the child, but primary responsibility is designated. This is information that you might have learned from the director, or as you first enter the room ("Does each child have someone assigned to them?") This "assignment" would include routine care and recording of information about the child (e.g., feedings, diaperings, naps, etc.) If the director says

there are assigned caregivers, but the caregivers say there aren't, or you observe that there is no system of care, code "NO." If the center rotates primary care every week (or so), code "no." This item is designed to assess consistency of care across time.

5. A chart or list refers to a standard form with specific places to record individual child information and includes at least sleep schedules and nutritional needs. This should be a standard pre-printed form, not just sheets of paper or a notebook, unless it is obvious that the notebook is used every day and contains the same information as would be on a standard form. The issue here is intentionality -- whether there is a formal system with prompts for recording information about the child. It should be readily available and used consistently over time. The purpose of this chart or list is for caregivers to refer to (not for parents). The list could in fact be provided by the parents.

6. A development checklist is a sequential listing of developmental skills.

7. An annual calendar is the teacher's document/record of two (2) past and/or projected dates for child assessments.

8. Self-explanatory, item examples provide elaboration. Look for a match between the child's level and the toys and experiences.

9. The focus of this item is on the procedure. Elements of this procedure might include whom to contact, under what conditions, type of information to provide, format for follow-up, format for parent communication, etc. All components of the description need to be there for a "yes." By procedure it is meant: a system of whom to contact, under what conditions, with what kind of parent follow-up, with what format - written or verbal. It is OK if the director seeks the referral, but ask the director what her system is. Again, the issue is intentionality; is there a system that everyone, including the parents knows how to use. It is OK if the caregiver indicates she would modify the procedure based on parents' personalities, as long as the key ingredients are present.

10. Teachers within a specific classroom and/or developmental group of children have a minimum of one (1) hour joint planning time on a weekly basis. Naptime does NOT count.

Items 11 and 12: All these items have to do with assessments, parent conferences, and documentation, and could be covered in the interview by asking, "Tell me about your procedure for parent conferences. What kinds of things do you discuss with the parents?" Generally speaking, the file should be a working file that the teacher keeps in the classroom, although it might be that the director keeps it. The calendar of parent conferences should be a written document, and you should be able to see the record of 2 past or 2 future assessments (item 11).

Parent conferences are one-on-one, not in a group meeting, like the PTA. If item 6 is "NO," then items 7 and 12 are "NO" because they are dependent upon assessments being done.

11. Self-explanatory.

12. Self-explanatory.

PHYSICAL ENVIRONMENT

These items are adapted from Wachs (1986).

1. Code "YES" if there is a place for a child to escape to. It should afford a reasonable amount of privacy, away from traffic and from major sources of noise. This does not necessarily mean that the child has his/her own room. A loft or pillow corner would count as a "YES." It also does not necessarily require a "permanent" place; a quiet space can be created as long as it meets the criteria outlined above. If there is a separate nap area in a room divided by a partial wall this does count as a separate nap area, as long as nonnapping children are not allowed in.

2. Crowding refers to the number of children and adults per available floor space. We have deliberately not quantified this item. Use your own judgment about whether the spaces where care for the target child occurs are crowded, taking into account the child's freedom of movement.

3. Again, use your own judgment about whether the space is cluttered and disorganized. Consider the arrangement of toys,

other materials, and furniture. Take the child's point of view and ask yourself if he/she experiences an environment in which toys and materials can reliably be found in the same place from day to day, rooms are consistently arranged, and there are not so many toys and materials as to be overstimulating/overwhelming.

ADULT NEEDS

1. An adult restroom and lounge are available, separate from children's activity areas. The lounge may be used, however, for children's activities on an occasional basis. The room contains adult furniture. Individual storage for teachers' belongings is available in the classroom or central storage is available in the lounge.

2. A professional library with current materials on a wide variety of subjects is readily available. "Readily available" means at the center (may be in the director's office) or in an adjoining building.

3. Regular staff meetings, which include staff development activities, are held. "Regular" means at least once a month. Off-site inservice training cannot substitute for staff meetings.

4. An adult group meeting area and conference space are available. Dual use must not interfere with meeting and conference scheduling, or the conference area is separate from the children's activities areas and other dual use. "Dual use" implies a high probability of scheduling conflicts. So, for

example, in a church-housed center, if staff meetings are held during the week in a room that is also used by the church on week-ends, then this is not dual use for our purposes. If a center classroom is used for parent meetings and conferences that occur only after-hours, then this is not dual use. In contrast, sometimes you will be told that a classroom is used for staff planning when the children are on the playground or taking naps. This is dual use, because there is a high probability that on any given day, one child will be too sick to go outside, or one child simply will not go down for a nap and so has to remain in the classroom.

5. Parent/staff information is exchanged at regular intervals through, for example, parent conferences, newsletters, bulletin boards. "Regular" means on an on-going basis (bulletin board) or at least monthly (newsletter).

6. Parents are made aware of the approach practiced at the facility through, for example, information sheets, parent meetings, etc. Parents may have input into planning and evaluation of the program.

7. Parents are welcomed to be a part of the program through, for example, eating lunch with the child, sharing a family custom with the child's class. Parents may be involved in decision-making roles along with staff. Code "YES" if parents are given the opportunity to be part of the program, even if they do not take advantage of it.

b. Assessment Profile for Family Day Care

SAFETY AND HEALTH

Again, one hazard constitutes a "NO" item.

1. Items which are hazardous to children are not within reach of children. Dangerous items cannot be obtained without extraordinary means (such as pulling a chair and climbing). This item pertains to the kitchen, bathroom or diapering area, and all other areas of the home which the children are observed to use. "Out of children's reach" means reasonably secured based on children's ages and abilities to get to hazards. If child must go to extraordinary means to reach dangerous items, then they are considered secure. This is one item when it is appropriate just to ask "Where do you keep cleaning supplies and sharp objects?" Ask her to show you where they are stored (observe). Indoors.

2. Electrical appliances (such as toaster, record player, radio, etc.) cannot be obtained without extraordinary means (such as pulling a chair and climbing). Electrical cords are not visible or are taped or tacked to prevent pulling or tripping. This item pertains to the kitchen and all other areas of the home which the children are observed to use. Cords can be taped, tacked, or out of sight.

3. Handles should be turned all the way toward back of stove.

4. Cleaning agents (such as ammonia, detergents, bleach, etc.) are not within reach of children. These items are in

locked cabinet or cannot be obtained without extraordinary means (such as pulling a chair and climbing). Child-proof safety latches are considered to be "locks." These agents are not stored on counter tops where food is prepared or in cabinets where food is stored - not in any proximity to food.

5. High chairs must have safety straps that wrap about the child's stomach and between the legs to prevent slipping off the high chair, under the tray. A tray is not sufficient to safely secure the child. (See center version.)

6. Cribs are safe -- mattress fits snugly within crib; mattress is low in the crib with at least 22 inches from the top of the railing to the mattress; side rails are raised and secured; distance between crib slats is no greater than 2 3/8 inches apart; no hanging crib toys are within reach of infant; no large toys which may become steps are in the crib. (See Center Version.) Child may have own mat, cot, or sheet.

7. Pathway is a passageway in which children and adults walk or crawl as they go from one place to another within or between rooms. Toys in use are not necessarily considered hazardous.

8. Heaters and fans are protected if they are located high out of the child's reach or have a screen or barrier that prevents the child's reach. Baseboard heaters are not safe if left unprotected.

9. Inaccessible electrical outlets are located too high for the child to reach without extraordinary means or are located behind furniture too heavy for a child to move.

10. and 11. "Good repair" means free of potential safety hazards for the child. Indoor and outdoor.

12. Written emergency procedures and an evacuation diagram should be posted for all pertinent hazards, as determined by the local geography or region of the country. For example, evacuation procedures for flooding may not be a presenting hazard but earthquakes may be. In this case earthquake evacuation procedures should be posted but flooding evacuation procedures should not. Evacuation procedures should include specific directions for relocating non-mobile infants. A simple diagram is not sufficient; a written procedure (such as: windows should be opened [or closed], take parent phone numbers, check specific areas of the home for children, etc.) for relocating children is posted. Both a diagram and the written procedures are intended for adult reference and should be included. The plan should include instructions for what to do with nonmobile infants. Ask about the amount of time it takes to evacuate.

13. If children use both upstairs and downstairs, the stairs should have gates at both ends. Bare wooden stairs are not non-skid. If gates are there but not used, code "NO." Closed doors do not count for stairs. Even if you never observe

them to be open, it is very risky to assume that they will never be inadvertently left open.

14. Each disposable or paper towel is used exclusively for one child or for one adult to prevent the spread of germs. If cloth towels are used they are used exclusively by one child. (See center version.) When only one child is in care, make sure that linens are not shared with any adults. If child is never observed to wash hands this would be "no."

15. Must ask (report): "Tell me about how you handle the diapers?" "You must go through a lot of diapers! How do you keep up with them?" If cloth diapers and a diaper service are used (and picked up once a week, for example), the container should be cleaned out daily and the days' diapers stored elsewhere (basement?) until picked up.

16. A disinfectant solution of 1/4 cup bleach to 1 gallon of water or other medically approved disinfectant is used. Lysol, soap and water, or baby wipes are not medically approved disinfectants. Ask "What is the solution you're using to disinfect the diaper area?" If you cannot identify it. If diapering surface is visibly soiled it must be wiped clean first and then disinfected. The use of protective tissue to cover the diapering surface is insufficient; the surface should still be disinfected unless tissue has a nonporous, plastic backing.

17. "Persisting odors" are odors that linger more than 15 minutes. "Lingering" means odors linger/persist more than 15 minutes.

18. Plastic, rubber and cloth toys that are available for exchange are washed daily to disinfect. Washing can be done with disinfectant solution soap and water or in a dishwasher. Equipment, such as highchairs, walkers, swings, etc., is also washed daily. Disinfectant solution (1/4 cup bleach to 1 gallon of water) or other medically approved disinfectants are used. If a bleach and water solution is used, this solution must be mixed daily. This item applies even when there is only one child in care for purposes of disease prevention. You may exclude this item if only the target child is in care.

19. It is not necessary that this information be posted. Provider must have ready access to this information; it may be in a file. Instructions refers to policies and procedures for when and how to provide treatment, or notification of parents, or isolation, etc. A first aid manual plus information on illnesses is okay.

20. "S"-shaped hooks pinched into "8" are ok. If children play regularly in a park (caregiver has no yard), code the park. Can get report on park, but code as "R." If there is no outdoor play equipment, code as "yes." In general, we code "yes" if equipment is not present.

21. Sturdy equipment is firmly built, no evidence of bending or loose joints. Firmly anchored equipment is stable in the ground and does not lift up with use.

22. Adult gardening equipment and tools are secured in locked shed or garage or stored. These items are not within the child's reach and cannot be obtained without extraordinary means.

23. Play area fence must be a minimum of 4 feet high (or there is no play area).

24. Self-explanatory.

25. The emphasis of this item is that a child cannot lock a bathroom door. If the door handle lock is covered with a child-proof cover to prevent locking, score this item "YES." But if the door can be locked, even though a key is within reach, score this item "NO."

26. Soap and water is necessary, baby wipes do not cleanse adequately and may NOT substitute for soap and water. This includes hand washing after blowing a child's nose. Score "NO" for even one missed opportunity.

27. This training must be current within the past two (2) years. Ask to see document; if it's not available, take her word for it. Must be infant CPR. Code "no" if caregiver's CPR or First Aid Certificate has expired.

LEARNING ENVIRONMENT

Code per "dominant mode."

1. "Accessible" refers to the child's ability to physically reach the toys and permission to access or use the toys; has permission to select without adult assistance. Must be accessible and allowed to use freely. Do NOT count toys that the children bring from home.

2. Containers can be plastic baskets or boxes and should be of a size from which the child can manage to obtain a toy or replace a toy. Shelves and containers should be at a level that is reachable to the infant so as to encourage infant exploration.

3. Materials that encourage musical exploration are readily approachable for children. There should be three different types (i.e., 3 different tape cassettes would represent 1 type of material). (See center version.)

4. Materials that encourage large muscle exploration are readily approachable for children. There should be three different types (i.e., 3 balls of different sizes would represent 1 type of material). An infant swing counts.

5. A special activity is a pre-planned activity that offers the child a novel experience that would not occur on a routine basis. (See center version.)

6. This system of toy rotation removes toys that children have lost interest in and introduces additional toys that may have been stored or that are new. The emphasis of this item is the existence of a system or strategies to maintain child interest. (See center version.)

7. Must observe in use, i.e., mere availability of item is not sufficient -- must see use of infant swing or infant carrier outdoors; or it is not possible to see it in use outside because of the weather conditions during your visit. An infant seat does NOT count.

8. "Variety" refers to three (3) types of toys and materials for outdoor use. Toys and materials are exploratory and portable items for infant use.

INDIVIDUALIZING

Individualizing pertains to all the children in the room/arrangement, not just the target child.

Code per "dominant mode."

1. Cubbies and containers may be baskets, boxes, bins, tote/diaper bags, or shelf-like structures with individual compartments. Code "no" for a child having his/her own room or closet.

2. Self-explanatory.

3. & 4. Looking for a system rather than a pre-printed form, although that would be ideal. It must be a systematic way of documenting allergies and special needs, such as medications, that is used consistently over time. A notebook with dated pages and recorded information will suffice.

3. Forms include child's name, date, description of special need or allergy, and desired care.

4. A chart, or form, includes child's name, date, description of child's behavior or needs. Variation refers to change in the child's routine behavior or needs with regard to sleeping, eating, toileting, end of day pick-up, etc.

5. Not a group presentation, but one-on-one with separate parent(s).

6. Not necessarily a form, but must be posted.

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Wachs, T.D. (1986). Models of physical environment action: Implications for the study of play materials and parent-child interaction. In A.E. Gottfried & C.C. Brown (Eds.), Play interactions: The Contribution of play materials and parent involvement to child development. Lexington, MA: Lexington.

G. HOME Observation Procedures

In general, the interview items from the HOME, the items involving observation of physical aspects of the environment (e.g., learning materials, safety issues) and items involving observations of caregiver's behaviors not directed at the child (#4, #5, #6) can be scored based on information obtained at any time during the 2 day visit. Scoring of items involving caregiver behavior involving the child (#1, #2, #3, #8, #9, #10, #11, #12, #13, #14, #16, #17, #29, and #35) should be based only on observations made during the first two hours of the visit on the second day. Do the interview portion of the child-care HOME on the second day just prior to doing the other interviews for the visit. First, go over your CC-HOME form to make sure all observable items are scored and then in a chatty informal way, ask for the additional information you need to complete the form. You may refer back in your conversation to things you have observed in the previous 2 hours. As with the PROFILE, once an item is scored it is best to consider it final. Otherwise you will spend much of your time coding and recoding and you have other data collection to complete. This also implies that you should not complete an item until you are confident that you have sufficient information on which to base your judgment.

1. Basic Concepts

The acronym chosen for the HOME Inventory (Home Observation for Measurement of the Environment)--effectively expresses many

of the major concepts underlying its development and represents some of the skills that will be needed by any person who uses it.

a. Child-care Home

The data to be gathered are collected in a home, not in an office, laboratory, or child-care center. The HOME subscribes to the philosophy that you can truly appreciate a child's behavior and development only if you have experienced the child's most intimate and powerful environment first-hand. A child-care home visit provides a richness of detail and a complexity of interchange that no interview can fully reveal.

b. Observation

Scoring for many of the items is based on what is observed during the visit, so obviously the HOME Visitor must be a good observer. Most of us think we are good observers, but often come away from a conversation with another person unable to report the color of that person's eyes or hair. Some concentrate so effectively on small details that aspects of the background are totally lost. One thing training in the use of HOME will do is help the user become a better observer of some of the small transactions between children and their parents and caregivers. Moreover, persons who are good observers have a head start in becoming proficient users of the instrument.

c. Measurement

The HOME is not just an informal data-gathering process; it is a systematic measurement of the caregiving environment. The measurement philosophy of HOME recognizes that skilled observation alone is not enough to allow a procedure to be useful for research purposes--or even for some clinical or educative purposes where precision of information is essential. Always there remains the onerous task of somehow converting the observations into quantifiable units. In the HOME we have used the simplest possible measurement system (counting) and the simplest type of item (binary). By observing whether certain events occur (parent praises child) and, if so, how often (at least twice), and then simply counting up the total of the designated behaviors, the amalgam of impressions and feelings is translated into a unified measurement system. For some clinical uses of the Inventory, one could stop short of this step; for research purposes, however, a commitment to measurement is necessary. When working with a caregiver, one is sometimes tempted to fall back on general impressions or feelings about the caregiver. There is an urge to give "credit" to those we like or feel empathy for. Lost in this process is the value of careful, objective description--the kind of information that leads to fuller understanding and more effective planning in behalf of the child and caregiver.

d. Environment

Although the Visitor goes only to the child's home-based child-care setting, an effort is made to appraise the quality of the broader developmental environment. Certainly during the early years, home, family, and caregivers constitute the most important environment that exists for most children. However, information is obtained in the course of the visit which helps to give a picture of the milieu in which the child's caregiving environment is embedded and the extent to which these experiences are strengthened by outside contacts likely to be meaningful to the child (e.g., trips to grocery store, visits with relatives).

These four components--actual visits to the home, a preference for observation as a means of obtaining information, a commitment to measurement, and a recognition of the importance for development of the environment--represent the major vectors of the philosophy which guided the development of the instrument.

2. The Interview

One important aspect of the procedure which is not covered by the acronym HOME is the interview that is necessary to obtain information to score some of the items. On the Infant-Toddler form of the Inventory, only one-third of the items will require supplementary interview data (although sometimes the visitor will have to ask questions about some of the toys, all of which may

not be visible during the visit). Thus, an essential skill for persons who will use the HOME is good interviewing technique.

Much has been written about interviewing in human services, and anyone without training and experience in interviewing should begin by reading some of the widely-used materials (Garrett, 1952; Shulman, 1978). Of particular help would be a document such as the Interviewer's Manual published by the Survey Research Center of the University of Michigan (1969). The anonymous authors of this widely-used manual remind us that interview respondents must (a) find an interview pleasant and satisfying, (b) consider it important and worthwhile, and (c) not regard it as something to be feared or that might result in personal harm (e.g., a damaging report to the Welfare Department). Although these precautions were written with survey research in mind, users of the HOME can profit from them.

3. Administration of the Child-care HOME

As already indicated, Child-care HOME items are sometimes based on information supplied by the caregiver and sometimes on direct observation of what transpires during the visit. Sometimes with older children, the information actually comes from the child. The Visitor will be observing and interviewing at the same time, but the instructions can be simplified if these two aspects of the procedure are separated for discussion.

a. The Interview

For this project, we recommend a standard interview for eliciting the information necessary to score the items which require information that cannot be obtained by observation. We also expect to have good interviewers. A good interviewer is a person who can be at ease in the situation, can put the caregiver at ease, can easily adjust subsequent questions to responses of the caregiver, and can ask questions in such a way as to avoid putting the caregiver on the defensive and thereby causing her to second-guess you as to what is the "right" or "expected" response. Your goal is to be objective and accepting, as opposed to approving or disapproving. This is essential if you are to find out how the caregiver feels and what the caregiver does with her child or children rather than what the caregiver thinks you want her to say.

Before actually conducting an interview, it is important to be completely familiar with the items. This will help you be more relaxed and will help the care provider feel less "on stage."

b. General Style

Obviously you must be careful not to ask questions in a threatening or judgmental manner. For example, rather than asking, "*Do you ever read stories to your child?*" it is preferable to ask, "*Do you ever manage to find time to sit down and read to her?*" If the caregiver answers affirmatively, you can explore further by inquiring, "*How often does he like you to*

do that?" You will note here that the burden of frequency is put on the child, not the caregiver; however, in her answer she will inevitably describe her own behavior, e.g., "He would like me to sit and read to him all day, but I can't do that. I tell him, 'I've already read to you, and one book a day is enough!'"

Although it is a good idea to develop techniques for avoiding seemingly accusatory questions, you should not be so concerned about subtle wording as to ask the question in a way that will elicit tangential and irrelevant answers to the items as worded. Reassurance for timid interviewers should be found in the fact that most caregivers believe that what they do with and to the children is for the children's own good, and they often report with pride actions that you might expect them to try to conceal.

Most of the information necessary to score the Inventory will flow forth fairly smoothly without the use of precisely-worded probes. It is better to get the information as the caregiver provides it rather than through the use of a rigid interview procedure. However, it is important to check each item before leaving the home. It is very easy to think that you have obtained all the necessary information, when actually you omitted some items. The single most common mistake made in using the HOME is that the Visitor does not get enough information to score all the items. We feel that it is advisable to call the

caregiver's attention to your checking of the items rather than have her make an inquiry about it. A simple statement such as, "I'm jotting this down because if I don't I tend to forget some of the things you tell me," will usually handle the situation nicely. Caregivers know you are there to learn about the child, so they are rarely concerned that you take notes or check your information before leaving.

c. Exceptions to Standard Procedures

Whenever one tries to define standard conditions under which procedures should be carried out, one immediately has to face the inevitability of more exceptions than standards. Such has certainly been the fate of HOME. In designing the instrument we opted for binary (either-or) choices rather than ratings along a continuum, for arbitrarily selected cutting points ("...no more than one instance of physical punishment occurred during the past week") rather than estimates of quantity and severity ("...uses physical punishment extensively, moderately, minimally"). We hoped thereby to eliminate a great deal of the subjectivity ordinarily associated with similar inventories. Accordingly, with each revision the items became more and more concrete and, we hoped, objective. However, significant objectivity for one situation reads "does not compute" for another.

For example, many of the items begin "Caregiver does..." something or other (reads to child, encourages developmental

advance, provides toys, etc.). As discussed earlier, this choice of wording reflects the orientation that the caregiver is indeed an important person in the life of the young child and will be a major interpersonal influence on the child's development. Of course, this does not mean that the caregiver will supply all the care provided to the child. For example, in homes with older children present, many of the activities covered by Inventory items might occur in the life of the child but might be provided by an older child. Some caregivers have responded to items such as "Caregiver reads stories at least three times weekly," with a statement such as, "I don't, but the older kids do."

The frequency with which such exceptions occur requires the articulation of an overriding principle which will help the user make decisions about the scoring of individual items. The intent of the assessment procedure is to get a picture of what the child's world is like from his or her perspective--i.e., from where the child lies or sits or stands or moves about and sees, hears, smells, feels, and tastes that world. If that principle is kept in mind, then you will not have to split hairs to score some of the items. The Inventory is attempting to assess the Child-care environment from the perspective of the child and is not exclusively appraising the caregiving abilities of the caregiver. Toys bought for other children but made available to the key child can still help in the acquisition of eye-hand coordination. Books read by an older child still foster language

acquisition. In order to obtain an accurate picture of the child-care environment, it is critical that we learn a great deal about the input supplied by the caregiver(s). However, a still broader portrait of the supportive qualities of the setting can be obtained by evaluating each exception in terms of the simple question: What is in it for the child?

d. The Observations

Throughout the session, you will be observing the behaviors of the caregiver and those aspects of the physical environment which comprise Inventory items. However, it is not a good idea to wait until the interview is completed to try to make a decision as to whether the behavior has actually occurred. Familiarity with the items and with the level or quantity of behavior chosen to designate success (e.g., kisses child once, verbalizes twice, etc.) leads to a general alerting on your part to such behaviors as they occur. A notation should be made on the Inventory form as quickly as possible. The recommended review of the Record Sheet at the end of the interview provides an opportunity to make certain that you have indeed paid careful attention to the kinds of behavior referred to in the observation items. You may have forgotten to praise the child in order to note the caregiver's response. If so, a quick check of the Record Sheet will serve as a reminder to set up the situation so that the caregiver's response can be observed.

Some people who use the Inventory have reported that they feel frustrated in making their observations for the interpersonal items because the really outstanding caregiver--the caregiver who verbalizes to the child 20 times during the visit rather than twice, the one who glows rather than smiles when the child is praised--does not receive a higher score than the one who is barely above the cutting point. In defense of this perceived weakness of the instrument, we offer a reminder of the major reason behind the development of the Inventory--the identification of at-risk environments where both the children and the caregivers could benefit from carefully planned intervention. You will have a opportunity to give the really terrific caregiver "4" in the Qualitative Ratings.

One final word should be said about reliance on observation versus interview for the items relating to play and learning materials in all versions. It was originally intended that these be observational rather than interview items. In most cases, this is how the items are scored. However, the visit usually takes place in the living area of the home or apartment, and frequently toys are not stored in this area. As long as the child is present during the session (which is *de rigeur*), certainly some toys will be brought in for the occasion. Furthermore, they will most likely be the ones which the caregiver feels are "good for the child" and will be the very ones you will need to observe. However, it is acceptable to ask

about other categories rather than demand to see the objects. If for any reason you feel that the caregiver is not clear on the type of toy asked about but says that she has bought one for the child, you might ask her to get it and let the child show how he or she uses it. This can easily be handled with good taste in such a way as to cause no discomfort to either the caregiver or yourself.

e. Scoring

All items on all forms of the Inventory receive binary scores--yes or no. Indicate "yes" with a "+" and "no" with a "-". No attempt is made to make finer gradations. The decision to employ a simple "yes - no" approach to scoring was made after careful consideration of many approaches, including the use of Lickert-type and Guttman-type scoring procedures. This binary format was chosen because it was difficult to come up with meaningful ways to operationalize Lickert or Guttman formats for each of the items. Rating scales such as "Always to Never" or "To a great degree to not at all," etc. were hard to fit to many of the items. Nor was there basis in the literature for *a priori* weightings for each item or a sample good enough to help establish empirically-derived weightings. This is not to say that other item formats are totally unfeasible or that the binary format is ideal for all items. In fact, the breakpoint between "yes" and "no" was established for some items with only a small

amount of information to guide the choice. However, this format seemed to provide the best fit among the available choices.

It is important to keep in mind the fact that all observation items refer to the contemporary situation--i.e., to conditions that prevail at the time of the visit. The time period covered by interview items varies; however, this is clear from the content of the item.

Except for those items where scoring criteria leave no room for leeway, the standard rule of thumb to apply in scoring is "what is appropriate for the target child." Toys useful in promoting hand-eye coordination in a 15-month-old are not the same as toys useful in promoting hand-eye coordination in a 30-month-old. Decisions about scoring must be made from the child's point of view. It matters not that the parent's "heart is in the right place" or that "she is doing a great job under the circumstances." What matters is what gets to the child.

The final thing to consider in scoring is to stick to the content of each item. The HOME is a standardized procedure. Like most other measuring devices, it contains a sampling of items from a much broader domain. Nonetheless, it is that particular sample that forms the "standard" of comparison. If the item says "Caregiver takes child to grocery store," visits to a department store do not count.

f. Completing the Form

It is advisable to complete the coding of the Inventory before leaving the house; do not trust your memory. Before leaving the home, the Visitor should have placed either a plus or minus mark alongside every item on the Inventory.

The items involving observation of the physical environment (Learning Materials, safety issues) and items involving observation of caregiver behaviors not directed at the child (#4, #5, #6) can be scored based on information obtained any time during either visit. However, scoring items for caregiver behavior involving the child (1-3, 8-14, 16-17, 29, 35) should be based only on observations made during the first two hours of the second visit.

4. Instructions for Individual Items

In the previous section, General Instructions, basic procedures for conducting the interview and making the observations necessary to score all versions of the HOME were given. In this section, specific instructions pertaining to the Child-care HOME (CC-HOME), Infant-Toddler version are presented.

For the experienced user of the HOME, the wording of the items on the Record Form will stand alone. However, until a potential user is completely familiar with the procedure, some amplification of precisely what is intended by each item is necessary. Such amplification for all items on the CC-HOME is provided in this section. Because of their simplicity and

binarity, the items are about as unambiguous as any scale developer can hope to achieve. However, language being what it is, some residual ambiguity is inevitably present in any abbreviated description of complex interactions or events. Accordingly, we have attempted to clarify precisely what is meant by each item in order to enhance reliable use of the Inventory.

a. Responsivity

This factor is defined as describing the extent to which the caregiver responds to the child's behavior, offering verbal, tactile, and emotional reinforcement for desired behavior and communicating freely through words and actions. Some of the items which loaded on this factor are based on responsivity of the caregiver to the Visitor rather than directly to the child. Obviously such items are based on the assumption that the caregiver's style of responding to the Visitor will reflect habitual patterns of social response and will therefore predict interaction modes between caregiver and child.

1. Caregiver spontaneously vocalizes to child at least twice.

"Vocalizes" refers to any sound or words emitted by the caregiver except scolding or chastising. For example, she may say, "S-s-s" or "Sweet baby," or any random words or sounds. In order for this item to be scored positively, the caregiver's vocalizations must have occurred

spontaneously as opposed to having occurred in response to some vocalization by the child. If the caregiver scolds or derogates the child repeatedly (i.e., far more than twice) but does not otherwise converse with him or her, this item should be scored negatively.

2. Caregiver responds verbally to child's vocalizations or verbalizations. Again the caregiver's response may be either a complete word or words or merely clearly differentiated sounds, e.g., "ta-ta," "tsk-tsk," or "You talking to me?" The key factor here is that the caregiver is responding to the child's vocalization, not ignoring it. If the child does not vocalize during the interview, thereby denying the caregiver an opportunity to respond, the score would still be "No."
3. Caregiver tells child name of object or person during the visit. The caregiver does not have to say, "That's an apple," or "We call this a purse," in order to obtain credit on this item. What is being measured here is the adult's sensitivity to the child's search for labels of objects around him. Credit for this item may be earned by a pattern of emphasis with the voice. For example, "Do you remember Miss Jones?" referring to the Visitor. She has

"taught" the word with her intonation and supplied a referent for the child.

4. Caregiver's speech is distinct, clear, and audible. A positive score on this item is determined by whether the Visitor is able to understand what the caregiver says. This item should not be interpreted as meaning that dialect usage mandates a negative score. What is important is whether the Visitor can understand and communicate with the caregiver.
5. Caregiver initiates verbal interchanges with Visitor. In order to be credited on this item the caregiver must demonstrate some initiative in asking two or three questions or making spontaneous comments that go beyond the bare minimum needed to give an answer. It is not necessary that she do this on all questions; however, occasionally she should take the initiative in the conversation and be a little wordy.
6. Caregiver converses freely and easily. In order to receive credit on this item, spontaneity is not as important as fluency. That is, the caregiver will be talking about things that are very close to her, and it should be very easy for her to express her ideas on this subject. A "No"

would be given to a person who tends to speak in one word sentences or to use headshakes when they would do. An occasional exception would not earn credit; the characteristic speech pattern should be noted.

7. Caregiver permits child to engage in "messy" play. This item was developed as one that should cluster with others in the general category of acceptance. However, it had a higher loading on this Responsivity factor and has accordingly been placed here. Certainly the caregiver who manages to allow a little messy play without getting too upset is responding emotionally in an appropriate manner. To be given credit, a caregiver does not have to disavow concern with wanting to see such behavior disappear from the child's repertoire; she must merely be willing to tolerate it occasionally. Included may be such things as playing with sand, mud, water, fingerpaints, or, for young babies, food.
8. Caregiver spontaneously praises child at least twice. In scoring this item, do not hesitate to read the caregiver's affect--any achievement reported with pride should count (can dress himself, has a good disposition, etc.). However, occasionally a caregiver will indicate approval of the child's behavior by making what appears to be a

negative statement--"I tell you, this kid is really bad."
If she says that with a smile on her face and immediately follows the statement with some rather remarkable achievement--"Would you believe he climbed out of his crib, got his bottle, and climbed back in all by himself?"--from which one can obviously infer that she is proud of him, then consider this one instance of praise. Do not credit this kind of semantic reversal if it stops with the negative term; score only if some proof of positive feeling is offered, and only if the compliment is spontaneous.

9. Caregiver's voice conveys positive feelings toward child.

What you are looking for here is evidence that the caregiver feels good about her child--sounds animated when speaking about him or her, does not use a flat or querulous tone of voice, etc. Generally the comments will be accompanied by positive facial expressions.

10. Caregiver caresses or kisses child at least once. Under "caresses" would be included a hug, a stroke of the hair, patting an arm or leg, reaching out affectionately and touching the face, etc. Blowing a kiss as well as actually establishing physical contact may be counted as a kiss. Simply touching a child does not constitute a caress.

11. Caregiver responds positively to praise of child offered by Visitor. In order for the caregiver to earn credit on this item, the Visitor must remember to offer some praise of the child. Make certain that your praise is genuine--i.e., do not try to force praise that you do not feel as you look at the child. Usually you will have no trouble deciding how to score this, as a caregiver might agree with you, add more facts to encourage you further, beam, etc. However, sometimes you will get little more than a "Thank you" said without feeling or an embarrassed smile. If so, find more than one occasion to praise the child. If you consistently get a response that shows no feeling or pleasure, then score negatively. Be alert to observe the caregiver's facial expression when you praise the child.

b. Acceptance

This factor covers the caregiver's acceptance of less than optimal behavior from the child and the avoidance of undue restriction and punishment.

12. Caregiver does not shout at child. A positive score on this item requires that the caregiver not raise her voice to a level above that required by the distance between her and the child.

13. Caregiver does not express overt annoyance with or hostility to child. A caregiver would receive a minus score on this item if she complains that the child is hard to take care of, that he is wearing her out, if she calls him "bad" without the affectionate joke described above, says he will not mind, and so on. Examples that would fail to receive credit would be remarks such as, "I don't know what I'm going to do with this kid," or "This kid is driving me up the wall." A caregiver might tell a child to stop doing something several times during the interview and still be credited for this item if her general tone is positive.

14. Caregiver neither slaps nor spansks child during visit. Occasionally a visitor will feel that she does not know whether a caregiver is playing with or seriously slapping or spanking a child. The best guide to use in such instances is the child's behavior. If the child reacts with pleasure or happiness, chances are this represents a style of positive interaction between her and the caregiver. If she frowns or looks unhappy or whimpers or cries, you can feel pretty confident that, however the caregiver intended it, she does not perceive it as pleasurable. Score "minus" accordingly.

15. No more than one instance of physical punishment during past week. Most caregivers define physical punishment as spanking; some apparently seem to regard it as true punishment only if something other than the hand has been used. Some caregivers regard restraint and shaking a child also as involving physical punishment. Our definition includes all of the above, even if the caregiver has a different idea (i.e., doesn't count unless a paddle or belt is used). If the child is hit, shaken, pushed against a wall or object, paddled, or just poked hard with a finger, score as physical punishment.
16. Caregiver does not scold or criticize child during visit. This item is obviously similar to #13 above. However, the main difference is that on this item the caregiver must make the negative remark directly toward the child. That is, "You are a bad girl," not "She (speaking to Visitor) is a bad girl." If such a remark occurs one or more times, score "-"; otherwise score "+."
17. Caregiver does not interfere with or restrict child more than three times during visit. "Restrictions" and "interference" here refer to such things as: taking a toy away from a child; putting a child who has climbed up on the sofa back down on the floor; putting a child who is

crawling around the floor into a playpen or crib; slapping a child as he starts to pick up the Visitor's handbag. In the last instance, the item would be applicable to both items #17 and #14. The restrictions may also be verbal--"Stop that"; "Get out of there." Do not code as interference any action taken to prevent the child from harming herself (e.g., running into the street).

18. At least ten books are present and visible. This item, and the one to follow, appear less faithful to the intent of the Acceptance factor than the others. Yet a *post hoc* explanation is always possible. Having books when there is a toddler present always poses a slight risk of having them torn or damaged, so their presence and availability identifies at least a willingness to cope with the child's curiosity and exploratory behavior--a clear form of acceptance. The same can be said for having a pet. A manipulable pet in the household of a toddler runs a definite risk! Caregivers who allow this are clearly being accepting of immature behavior.

The word "visible" was added to this item to make it an observation and not an interview item. However, being able to observe whether there are books present in the home might require a request to go through the entire house or apartment without a spontaneous invitation to do so from

the caregiver. In such instances, do not hesitate to ask about the books that are available. The item will help indicate whether the child is growing up in a child-care setting in which reading and having books around are valued. For example, there might be an encyclopedia on the shelf that has obviously not been read. Even so, credit would be given for the item, as the presence of the books indicates that they are valued. This item does not refer to children's books but the books should be located so a child can see them (not in a box in a closet).

19. There is a pet. It seemed incredible that this item could have any content ambiguity, but apparently some Visitors have had trouble deciding whether one or another type of animal that has temporary residence in the setting can truly be called a pet. In our definition the word refers to an animal that is taken care of in the child-care setting (including the child's own home) and the child can play with or look at--i.e., one that stays in the setting on a semi-permanent rather than a temporary basis (such as a dog, cat, bird, turtle, goldfish, hamster, as opposed to a captured grasshopper, a lame bird, or a jar full of lightning bugs, etc.).

c. Organization

This factor refers to the extent to which there is regularity and predictability (without monotony) in the caregiving schedule, to the safety of the physical environment, and to the inclusion of community services as part of the caregiving support system.

20. Caregiver is one of not more than three regular substitutes for child. There is really no need to inquire about this, in that the mother will already have supplied the information. However, the item is included here because the wording is slightly different from that on the regular Inventory form ("Child care, if used, is provided by one of 3 regular substitutes"). The mother is more likely to have the information necessary to score this than the caregiver, unless the caregiver is the father. In order to get the information during this session, ask, "Are you the only person who takes care of CHILD while his/her mother works?" If the answer is negative, follow up with, "Who else does this?" Then ask, "How many people are there altogether, including you?" If the caregiver is joined by other people for part of the day on a regular basis (e.g., older sibs who show up every day at 3:30 and spend some time with the child, a neighbor who comes in regularly each morning for coffee, etc.), do not count these as extra caregivers

unless the primary caregiver leaves the child totally in their care during those times.

21. Child is taken on an outing at least once a week. "An outing" can be broadly defined. It may be a walk to a neighborhood park to use the slide/swings. It may be a trip to the grocery store, a visit with a neighbor next door who has a child or children. It should be more than merely going out in the yard to play.
22. Child gets out of house at least four times a week. The infant/toddler may be taken no farther than the yard in order for credit to be given. The intent of the item is exposure to sounds and sights and objects and people other than those routinely available within the house or apartment.
23. Caregiver has an emergency medical and/or accident plan. This is a requirement for all registered or licensed family day caregivers, so the visitor could ask to see the plan. For more informal arrangements, the visitor will have to ascertain whether the responsible caregiver has thought about this, has a plan, has phone numbers and names written down, etc. The visitor should ask, "Tell me what you would do if you had an emergency with CHILD." If there is any

reason to doubt the accuracy of the response, ask, "Where do you keep your list?" With this kind of probe, the caregiver will generally get it and show it to you.

24. Child has a special place for toys and treasures. This item will reflect the predictability of the child's environment. The special place may be a closet, drawer, a plastic basket, or even a cardboard box or paper bag. It need not be a fancy chest especially sold for children's toys. It does not have to be in a special room. The accessibility of the special place for either removal or returning of toys by the child is the essence of the item. The special place does not have to belong exclusively to the key child; it may be shared with another child.
25. Child's play environment is safe. The Visitor should use her own good judgment in scoring this item. Examples of hazards are: broken glass lying around, furniture with wood splinters or exposed nails or pins, an uncovered rotary fan, boards with nails sticking out, unprotected stairs for a pre-walking baby, house so close to the street that child could not safely play in the yard, pot handles extending over edge of the stove, etc. Overcrowding or clutter would not count as a hazard unless it existed to the extent that it could injure the child.

d. Learning Materials

This factor deals with the provision of appropriate play and learning materials capable of stimulating development. The factor could have been called something like Toys and Equipment to Support Development. Historically, we did call it that and various other things at different times in the past. But in trying to shorten all the subscale labels, we settled on the true common denominator of the items included here--they are materials which, when used by the child, provide tools for the development and refinement of crucial skills which must be acquired during the infant/toddler years. Thus we have relabeled the subscale, Learning Materials.

In scoring items in this section, it is important to keep in mind the developmental function served by each type of play equipment mentioned. What is crucial is not whether the toys are shiny and new and expensive or whether they are home-made or hand-me-downs. What is important is whether they will allow the child to touch, feel, manipulate, move, listen, and have fun in the process! Also it is not critical who purchased the toy. What matters is its availability to the child.

For each of the items in this subscale, the child must have access to the toy or piece of equipment. If someone has purchased the toy for another child but the child who is the subject of the visit is prohibited from using it, then credit should not be given.

26. Muscle activity toys or equipment. Examples are crib gym, ball, rocking horse, jumpseat, door swing, or any of the items mentioned in #28. If such equipment had not been provided by the caregiver but is available in the childcare setting, the item should be credited so long as the infant or young child is granted access to it. Also the item need not be identified by the caregiver as "belonging" to the child; it might be shared with other children. However, it must be available for use. Thus, for all the toy items, credit would not be given if someone had bought the toy for the child but it had been lost, broken, or stolen. In such cases it would not be available.
27. Push or pull toy. Examples are toy lawnmowers, vacuum or carpet sweepers, corn poppers, music boxes on a stick, xylophone that is pulled by a string, wagon, etc. Credit also a shoe box with a string attached, a real carpet sweeper (with which the child can regularly play), or a kitchen stool on wheels.
28. Stroller or walker, kiddie-car, scooter, or tricycle. These items are all self-explanatory--anything with wheels that a child can ride on or in, or a large wheel toy that the child can manipulate.

29. Caregiver provides toys for child to play with during visit. In order to be credited on this item, the caregiver must make some special effort to see to it that the child has something interesting to do during the visit. If the visit is conducted in a room that contains a number of toys or the child's toy box, one should assume that the caregiver has taken special efforts to have something available to entertain the child during the interview. If, however, the child tires of what is available and begins to whimper or to ask for something to do, this item should not be scored unless at that time the caregiver makes some special effort to bring out a new toy or do something else to interest the child.
30. Cuddly toy or role-playing toys. This is an item that has a certain amount of age flexibility. For children up to about 18 months, a teddy bear or other stuffed animal or doll would provide the tactile experience presumably offered by a cuddly toy. For children between roughly 18 months and three years, any kind of doll or stuffed animal that stimulates make-believe would be credited. It may occasionally be more difficult to decide on this item when the key child is a boy, as families are often loath to provide their boys with anything that is "sissy." In such

cases a cowboy suit or policeman's or fireman's hat would be acceptable. Cowboy boots would not.

31. Learning facilitators--mobile, table and chair, high chair, play pen. What is essential here is that the caregiver provide the child with a piece of equipment considered necessary for various types of learning to occur, not just with a toy. (Mobile was included in order to have something applicable to very young infants.) The play pen may seem out of place in this item. It was included because it provides a safe environment in which an infant can play when the caregiver cannot provide direct supervision. In order for a play pen to be used for a positive score on this item, the caregiver should indicate that toys are placed in it whenever the baby is there.
32. Simple eye-hand coordination toys. This item involves such things as small objects that can be placed in and taken out of a receptacle, toys with more than one part that can easily fit together, large beads to string, etc. The items should be fairly small and should require precise hand movements--the child should not be able to move around and manipulate them at the same time.

33. Complex eye-hand coordination toys. Obviously this item is similar to the previous one, and Visitors will have to make an occasional judgment call as to whether a given coordination toy is "simple" or "complex." Both simple and complex manipulation toys often involve the combination of components. The key to the judgment of complexity is whether the combination that results from the child's manipulations can create an item that is more than and different from that created with repetitive combinations of similar identical components. Thus beads to be strung (resulting in more beads on the string if successfully manipulated) is a simple eye-hand toy; so, too, are button/zipper/snap toys, snap beads, geometric shape sorters, ring cones, busy boxes, and cobbler benches. Lego blocks (which can result in shapes totally different from the shapes of the individual pieces) would be a complex eye-hand toy. Other examples of complex coordination toys would be nuts and bolts, Lincoln Logs, Tinker Toys, etc. In scoring this item, the Visitor must remember that what is crucial is not whether the infant/toddler uses a potentially complex toy in a mature fashion (e.g., tries to make a house with Legos) or uses it only in a somewhat pedestrian fashion (e.g., makes a "road" out of bricks all the same size). What is being measured is what the caregiver has provided, not what the child can do.

34. Toys for literature and music. This includes tapes, books, records, toy musical instruments, etc. Although the "literature" part (books, talking records) of this item seldom causes any trouble, the "music" part does. A record player that the child may manipulate would be a perfect example in that both story records and music records could be played on the instrument. Again consider the age of the child in scoring this item. For example, a rattle with a musical jingle would be acceptable for a baby but not for a toddler. The radio is acceptable if the child is allowed to turn it on and select a station. The same would be true for a record player. If the family record player is accepted, then the child must be permitted to manipulate it. At least two such toys must be available (one for literature and one for music) in order for credit to be given on this item.

Throughout items #30 - #34, the key to scoring is that the child be allowed to manipulate the play item even though he/she may not choose to do so. For example, the caregiver may report that she has bought blocks for her child but that the child never plays with them. In such instances, inquire in order to determine whether this is because the child is not interested or whether they have been kept from him or her. "Provides" requires that the child is not forbidden to touch, handle, or play with the item. The

caregiver does not have to be the one who bought the items. What is critical is that the items be available to the child.

e. Involvement

This factor defines the extent to which the caregiver is actively involved in the child's learning and provides stimulation for increasingly mature behavior.

35. Caregiver keeps child in visual range, looks at often.

This is an interview item pertaining to times when the caregiver and child are at home together. "Often" means frequently enough to ensure safety of the child and to keep some kind of interpersonal contact going--the sort of thing lovers do when in the same room but out of reach of one another.

36. Caregiver "talks" to child while doing household work.

"Talking" to the child in this item means that the caregiver in the course of her or his own work activities finds a way of including the child in what is going on. The caregiver may talk directly to the child, e.g., "Well, I'm going to wash these dishes now"; or "It's time for me to wash the diapers." Perhaps the caregiver may simply talk as though to the child as she goes about her work, "I

don't see how we can get a house so dirty." The critical thing is that these comments occur within hearing range of the child or possibly with direct eye contact.

37. Caregiver consciously encourages developmental advance.

The first key word in this item is "consciously," as it is indicative of a teaching attitude on the part of the caregiver. The second key word is "encourages." In order to encourage, the caregiver must do more than just "allow" the child to develop or a particular type of behavior to occur. Instead, the caregiver must take an active role (e.g., arrange the circumstances to assist development, praise the child's efforts, provide specific opportunities for behavior to be rehearsed). Credit on this item is given to the caregiver who finds little ways to help the child learn to roll over, who occasionally puts a toy out of reach to encourage crawling, who gives the child a spoon to let her try to feed herself, who tries to teach patty-cake, etc.

38. Caregiver invests maturing toys with value via personal attention. Maturing toys are those which, the first time the child is introduced to them, call for abilities a little bit beyond any demonstrated to date. Thus they involve the acquisition of new skills and offer the child a

challenge. Many times caregivers will present such toys, put them down in front of the child, and assume that the child should go on alone from there. Success on this item requires that the caregiver "talk up" the new toy, sit down and play with it herself or himself with pleasure and glee, or show the child how it can be used and encourage play with it. The encouragement should be participatory, not via some command like *"Go play with the fancy blocks I gave you."*

39. Caregiver structures child's play periods. This does not mean that the caregiver must decide everything that the child should do throughout the day. Rather it refers to one who recognizes the short attention span of the young child and the need to offer occasional suggestions as to things the child might do. Structuring need not involve any request that the child play. For example, the caregiver who notices that her child is fretful, who then goes and gets a corn popper and puts it down in front of the child is structuring the play period. Credit should also be given for a more verbal caregiver--i.e., one who says, *"Why don't you go and get your corn popper and play with it."*

40. Caregiver provides toys that challenge child to develop new skills. Scoring this item requires some awareness on the part of the Visitor of toys that are and are not appropriate for children of a given age level. What is being assessed here is the caregiver's skill at estimating the child's ability and interest level and at finding materials that will challenge further development. Credit should be given even if the caregiver appears to overestimate the skills that the baby is ready to begin to acquire.

f. Variety

This factor encompasses the inclusion in daily life of people and events which bring some variety (without disorganization) into the child's life.

41. Mother provides some care daily. This is another item for which information will already have been provided during the session with the mother. On the original Inventory, the parent referred to in the item is the father. Presumably the item loaded on the Variety subscale because, in a home setting in which the mother is the primary caregiver, the father introduces some variety into the daily schedule. In at least some of the settings in which we use this version of the Inventory, the father will be

the one providing care. Accordingly, we need to know whether the mother provides some of the child's daily care during the hours that BABY is in child care. In in-home care settings, use of the question as written will suffice. In care arrangements in someone else's home (family day care, relative care with or without pay, etc.), we would begin with the question, "Who usually brings and picks up CHILD?" If this is the mother, then obviously she provides some care. If not, then ask, "Does the mother ever come to visit CHILD while he/she is in your care?" If the caregiver says he/she doesn't know, then score negatively. Accept any other answer given and score accordingly. Do not count maternal care that occurs beyond the hours CHILD is in this child-care arrangement.

42. Caregiver reads stories to child at least three times weekly. This should refer to a children's book or magazine and, for toddlers, should be more than merely turning pages of a magazine and saying words. If the caregiver says, "I don't, but her father or the older children do," score "+" if the designated reader is old enough to be a true reader.
43. Child eats at least one meal a day with caregiver and/or other children. The purpose of this item is to determine

whether during mealtime the baby/child is in a social situation or is isolated. If the caregiver sits with the child but intently watches TV or talks to a neighbor, this would not count as social interaction. A visitor is not likely to see this during a visit. If, however, the caregiver pays more attention to the TV than to the visitor during the interview, this is a pretty good indication that the same thing would occur at other times. Ask, "How do you manage when one of your programs is on when you have to feed CHILD? Does he/she demand all of your attention? Or can you feed him/her and watch at the same time?" For toddlers in family day care settings, a positive score requires that the children be fed with or near other children who are eating. It does not require that the caregiver sit down and eat with the children.

44. Caregiver and child visit or receive visits from neighbors or friends once a month or so. This item is self-explanatory. Does anyone come in to provide a bit of variety in the daily routine? Does the caregiver make the effort to extend the child's world by brief visits with other people? (In registered and/or licensed family day care, taking the child to some other home is not likely to happen. Any trips outside the home are likely to be of the field trip variety, which would be scored under 21.)

45. Child has 3 or more books of his own. If the setting is family day care, the books may be shared with the other children; they do not have to be identified as belonging exclusively to the index child. What is critical is that they be accessible to the child. If the setting is in-home care without other children present (but with other children perhaps being present part of the time), the books should be identified as "BABY's books."

5. Specific Instructions for Observing and Interviewing

As stated in the previous section, we recommend flexibility in observing and interviewing during the home visit in order to obtain valid information about the child's current home environment. Real homes are alive and dynamic, and most caregivers are spontaneous and animated when they talk about children. In such instances you will get a better picture of the environment if you allow the caregiver to lead, accommodating information they provide to the wording of your items, and probe only when necessary. With other caregivers, of course, getting information is like pulling teeth. In such instances, you will need to check your interview prompts, note (if you have not already memorized it) the exact wording of the items, and make certain that you get all the needed information. Even in such homes, flexibility and informality on the part of the Visitor are

needed to avoid an atmosphere which seems intrusive, formal, and businesslike.

a. Specific Instructions for the Observations

With the exception of Items 7 and 15, the first 18 items on the Infant/Toddler HOME are based entirely upon observation. Items 7, 15, 20-23, 35-39, and 41-45 depend largely on the interview. Items 19, 24, 26-34, and 45 can go either way. That is, observation may yield all the information necessary for scoring. However, if not, it is probably better to get the necessary information by interview on these items than to have the Visitor request to see a part of the house other than the area which the caregiver has set up for the visit. Item 40 is technically neither observational nor interview-dependent. It requires a judgment call based on what is seen and learned during the visit.

Even though the first third of the Child/Care HOME is based almost exclusively on observation, the Visitor should not expect to make the observations within the first third of the visit. In fact, none of the items can really be scored until the very end in that they pertain to behavior that might occur at any time during the visit or else to a specified number of occurrences over the entire observation period (e.g., praises child at least twice).

Essentially what you are observing is the nature of the interaction between the caregiver and the child. Even though the items are binary and sound very cut and dried, they manage to communicate the tone of the interaction: Is it warm and loving or distant and possibly hostile? Is there mutual pleasure in the relationship or annoyance and frustration? Are the needs of the child recognized and accepted, or are things run primarily on the caregiver's terms? These subtle manifestations of the nature of the home environment will indeed show up in the observation items.

Knowing the items in advance of the visit and being familiar with the exact cutting points chosen for the binary items (e.g., once, twice) will help the Visitor remain alert throughout the visit for the requisite number of occurrences. When you are finally completing the form it is crucial to check and record in case you need to "stage" something you might have forgotten (e.g., praising the child to note the caregiver's response) in order to be able to score all the observation items.

b. Specific Instructions for the Interview

The following interview schedule is to be used to obtain the necessary information to score all CC-HOME items not scored on the basis of observation.

1-6. Observation only.

7. "Young children often put their hands in their food or in something else that's messy - like mud - and want to play with it. How do you handle it if he/she tries to do that?"

8-10. Observation only.

11. This item (Caregiver responds positively to praise of child offered by visitor) does not require an interview probe. It is listed here merely to remind the visitor to be sure to offer praise in order to observe the caregiver's response.

15. "Do you sometimes have trouble getting him/her to do what you want him/her to do?" Wait for answer, then ask specifically, "Have you ever had to spank him/her?" If the answer is affirmative, ask, "How often did you have to do that last week?"

16-17. Observation only.

18. Do not ask if observable (availability of 10 books). If not, ask "Do you find that you have time to do much reading?" Wait for response, then ask, "Do you have any books for yourself here in the house?" If you don't get some number, then simply ask, "Do you have as many as ten?"

19. Observation generally. However, if none is observed, ask before scoring negatively, "Do you have any pets?"

20. "I understand that you are the main person who cares for CHILD while his/her mother works. What happens if you are sick or have to be away from several hours or a whole day?" Keep inquiring until you know whether there is a regular back-up system of not more than 2 other people. (Note: this item can actually be scored from the mother's report during the 15-month Home Visit if the caregiver does not know.)

21. "Do you ever take CHILD (the children you care for) on little outings?" If no, the scoring is obvious. If yes, ask for an example and then ask about how often he/she does this.

33. "Do you take CHILD (the children) outside very often?" Follow-up on whatever he/she says to determine whether this occurs at least four times a week.

23. "What would you do if you had an emergency with CHILD?" If the response does not include information that the plan (phone numbers, contact people, etc.) is written down somewhere, ask, "Do you have to remember all of this, or do you have it written down somewhere?" If you doubt caregiver's veracity, ask to see the list.

24-35. Observation. If this is a family day care home, the interview will most likely take place in the room in which most of the care is provided and will contain the accessible toys. If it takes place in a living room, you may have to inquire. If so, ask a general question, "Tell me about the toys you have for CHILD to play with." Check off types as mentioned, but do not assume that failure to mention means unavailability. If necessary, ask about each type, using essentially the wording on the scoring form.

36. "What do you do with CHILD (The children) while you take care of some of the other things you have to do each day?" (Be careful not to suggest the scorable answer with your questions.) "Do you put him/her in his/her (crib, play pen) while you get the lunch (straighten the room, clean the bathroom, etc.)?" Then, if necessary, try, "Do you keep him/her in the room with you when you do those things?" "Is he/she interested in what you are doing?"

37. "Have you tried to teach CHILD any little games like ring-around-a-rosie?"

38. "Is CHILD interested in the toys you have for him/her?" Whatever the answer, ask, "How do you get him/her to play with the toys?"

39. "Children this young often can't pay attention to anything very long. What do you do if he/she seems restless or bored?"

40. Observation. Make your own judgment here.

41. If this is family day care, ask, "Who usually brings and picks up CHILD?" If "His/her mother" is not the answer, ask, "Do you know whether CHILD's mother takes care of him/her part of the time every day?" See the manual for details on this item.

42. "CHILD's pretty young for books, I suppose. Do you ever read little books to him/her?" If the answer is affirmative, ask, "About how often do you do that?"

43. "How do you handle mealtime with CHILD?" (Check the manual for possibly necessary probes on this item.)

44. "Do any of your neighbors come over and visit while you are caring for CHILD?" Wait for answer, then ask, "About how often does that happen?"

45. Observation is usually sufficient. If necessary, ask, "Are there any books here that CHILD can look at or try to hold?" If this is a family day-care setting where other children are also present, books that are accessible to the children count; they do

not have to belong exclusively to the target child. In a home setting without other children, they should "belong" to the child.

IV. TROUBLE SHOOTING FOR THE ENTIRE VISIT

Here are some of the problems we have anticipated with suggested actions.

-The child is absent:

Try to find out why the child is not present. If the child is sick, call the parent to find out when the child will be back so that you can reschedule your observation within the allotted window.

-The children go for a walk, to the store, etc.:

Continue observation.

-A crisis arises during your visit and the caregiver asks you to babysit:

You are not a babysitter and cannot be responsible for looking after the children in her care during her absence. He/she should make whatever arrangement he/she would have if you were not there. (However, when a conflict between scientific and ethical principles arises, be ethical, be humane, use common sense and good judgment, call your PI or PC.)

-A child is in danger and the caregiver is busy elsewhere:

Do not let an accident happen while you stand by. Alert the caregiver or intervene.

-The child lies down for nap or goes to sleep:

--during the first observation cycle on Day 1: If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes, then do the Profile observation. Ask the caregiver if the child is likely to awaken in the next hour or so. If this is likely, you may want to wait to do another observation cycle; if you do not want to wait, give the caregiver(s)

the questionnaires, schedule a second visit and leave. You will have to do 3 observation cycles on Day 2.

--during the second observation cycle on Day 1: If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes, then do the Profile observation. Give the caregiver(s) the questionnaires, schedule a second visit and leave. You should do 3 observation cycles on Day 2 so that you can discard this short one, but if 3 cycles on Day 2 are not possible, this cycle will be used.

--during the third observation cycle on Day 1: This was your insurance cycle. If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes, then do the Profile observation. Give the caregiver(s) the questionnaires, schedule a second visit and leave. You will need to do 2 cycles on Day 2.

--during the first observation cycle on Day 2: If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes. Ask the caregiver if the child is likely to awaken in the next half hour. If this is likely and you only did 2

observation cycles on Day 1, you may want to wait to do another observation cycle; otherwise, you will need to schedule a third visit. Do not do the interviews until you have (at least) 4 observation cycles complete.

--during the second observation cycle on Day 2: If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes. Then proceed with the interviews.

-The child becomes aware that you are observing her/him:

Stop the audiotape and turn your attention to another part of the room. After 2 minutes resume your observation. Do this only once. After that avoid eye contact. Look away, at your papers, the wall, another child, or the caregiver (and code child's activity as "unoccupied/watching" if child continues looking at you.)

-The target child or another child persists in interacting with you:

Attend to the child briefly by telling her/him that you have to work. You can begin writing or redirect your attention elsewhere. If you were sitting, try standing up to do the observation. If you were located in the midst of the children's activity, try moving to another position.

-The caregiver leaves or goes on break in middle of observation:

Go on observing. When the observation is complete, if the caregiver is just on break, you can do the interview during or after the break. If the caregiver has left the premises you can do the interview over the phone. (It will be important to know the schedule of the primary caregiver, especially when he/she usually leaves, before you schedule your visit, so as to avoid these situations.)

-The caregiver attempts to engage you in conversation during the observation: Let her/him know that you do want to talk, but that you have to time the observation. Tell her that you will have an opportunity to talk at the end of the observation (in about x minutes, or on your next visit).

-The mother shows up while you are observing:

Stop the observation and wait till she has gone to start it again. Perhaps you could do the Profile observation in the meantime.

-The caregiver asks you what you are observing:

Only general information should be given to caregivers and should be specific to questions actually asked. Emphasis should be on

our wish to capture the child's experience in the setting and not on any desire to evaluate the quality or adequacy of the center, home, or caregiver. Emphasis should be on the "exploratory" (vs. evaluative) nature of the data collection: We don't know how children's experiences contribute to their development unless and until we collect information about those experiences.

-The parent asks for information about the child-care setting:

Most times the person talking to the parents will not have any information about the child-care setting because a different observer will be making these visits. Parents who ask, however, should be encouraged to observe in their own daycare sites, to talk to their caregivers about their concerns, etc. They should also be told that decisions about day care arrangements are personal ones, and that what makes one parent comfortable will not necessarily make another parent happy; hence our advice is not as important as the parents' personal observations and values. You could also say that the caregiver has signed a consent form assuring her that the information you collect will be confidential.

-The care you are observing is suboptimal:

It is our responsibility to report any clear cases of abuse or neglect (see Manual for 1-month visit for details). If care is not truly abusive or neglectful, however, although it may be

chaotic, inattentive, noisy, or bleak, it is not appropriate for the observer to intervene or to report the inadequacy of the care to the parent. To do so would jeopardize our opportunity to gather data on less than ideal day care. Potentially life-threatening or injurious, but not abusive, practices (e.g., open fire, open stairway, open window, small toy parts available to children, etc.) should be brought to the attention of the caregiver(s)/director and to your PC and PI. If not remedied it may be appropriate to bring it to the attention of the parents.

-The caregiver asks for information about child care, the child, child abuse, etc.:

Tell the caregiver you need to check with the PI/PC, and then together you can come up with some reasonable and specific answer. It has been suggested that we put together a packet of resources for caregivers, but I think we should just have such a packet on the PC's desk and draw from it selectively and only as requested/required.

V. 15 MONTH CHILD-CARE ASSESSMENT: OVERVIEW FOR SEASONED (6-MONTH) OBSERVERS

The same procedures will be followed at 15 months as at 6 months for recruitment, obtaining consent, order of procedures, number of visits, number of observation cycles, ORCE coding,

administration of observations, interviews and questionnaires, and training and reliability.

TIMING OF VISITS

The first child-care visit should occur within the period between the child's 14- and 16-month birthdays. The second visit should occur about a week after the first visit and definitely not after the child's 19-month birthday. No arrangement or classroom should be visited until the child has been enrolled for at least 2 weeks. Child-care assessments should be made within 1 month of the 15-month home visit, preferably within 2 weeks. If the child-care setting is the child's own home, the child-care visit should be made after the home visit; if the child-care setting is another home or center, the order of visits is not so critical.

QUESTIONNAIRES

The questionnaires are the same as at 6 months except that "My Baby" (Temperament questionnaire) has been dropped and "My Feelings" (CES-D) has been added. The other questionnaires are the same as before:

"When Parent Leaves/Returns" (McCartney Pick Up/Drop Off), "Ideas about Raising Children" (Schaefer Modernity), and "Taking Care of Young Children" (Marshall Caregiver Stress).

PROFILE

The PROFILE is the same.

HOME

The HOME is the same except the items have been re-ordered.

ORCE

The ORCE remains much the same, with the addition of several new behavior scales and a new qualitative scale. There are also some changes in rules about double coding and some reorganization and re-ordering of scales.

New Behavior Scales:

Caregiver gives direction

Caregiver speaks positively

Caregiver talks to group

Other activity with objects

Other activity without objects

Child says "no" / refuses

Child acts defiant

New Category for behavior scales:

Activity Setting

With adult (and children)

With children only

Alone

New Qualitative Scale:

Child's engagement with caregiver

In addition, the descriptions for many of the existing scales on the 6-month ORCE have been modified to apply more specifically to 15-month olds.

INTERVIEWS

In general, the interviews at 15 months are the same as at 6 months.

Mother Interview for Child Care We Cannot Visit

SAME

This phone interview should also be used (a) whenever it is discovered during an "update phone call" at 9 or 12 months that a child has started child care or changed child care and, (b) for sites that desire it, for secondary child-care arrangements.

Director Interview for Child Care We Cannot Visit

SAME

Director Phone Interview

SAME

Center Caregiver Interview

If the caregiver has never been interviewed before -- SAME

If the caregiver has been interviewed before, either for the target child at 6 months or for another child in the study, use the CENTER CAREGIVER SHORT FORM.

Director Questionnaire

If the director has completed the questionnaire before for target child or another child in the study, use the "Director Questionnaire for Centers we Have Visited." If the director has not completed the questionnaire before, it is the same.

Father as Caregiver Interview

If father was not interviewed as a caregiver at 6 months --
SAME

If father was interviewed at 6 months use Father Short Form
-- NEW

Mother as Caregiver Interview

-- New

Home Care Provider

If this is a new caregiver who was not interviewed before -
- SAME

If same caregiver as at 6 months, use HOME PROVIDER SHORT
FORM

VI. TRAINING AND RELIABILITY

Becoming reliable on the qualitative ratings and behavior scales, and on the Profile and the Child-care HOME, requires that observers (a) be extremely knowledgeable of the coding manuals, (b) apply this knowledge to the task of watching children and caregivers, and of rating environmental quality, and (c) use the same metric in their assignment of ratings as that used at the other nine sites.

The task of creating reliable raters across 10 sites as part of a longitudinal study is formidable. The successful implementation of the Qualitative Ratings and Behavior Scales is dependent upon observers in all the sites using the same "cut" points when they make their ratings. Similarly, it is crucial that observers code the Profile and Child-care HOME comparably.

But, there are many difficulties. Not all observers will be attending the live training. A method of training these people had to be found. Another difficulty is that consistency in ratings must be maintained over a 10-month period. Observer and site drift must be minimized. Also, because new observers may be joining sites as the study progresses, a way had to be found to insure that these new observers are trained in precisely the same way as previous observers. A final difficulty in this 10-site collaboration is that child-care quality may vary systematically across sites, resulting in a different internalized metric at different sites.

For each of these reasons, we adopted a strategy of using comprehensive training films with accompanying text that can be used and studied at each site for the qualitative and behavioral ratings. The Profile and Child-care HOME measures cannot be captured on video, and require somewhat different training and reliability procedures, as described below.

1. Preparation of Training Tapes for the ORCE

An important component of training is for coders to experience the full range of child-care settings and experiences. Therefore, videotapes of infants in day care centers, family day homes, nanny care, father care, and grandmother care were collected. Children were videotaped during feedings, diapering, play periods, and when they were left unsupervised. Children were also taped in child-care situations that varied widely in quality. Diversity in terms of the childrens' and caregivers' ethnicity, race, social class, and geographic region was important. From this video library composed of many hours of tape representing nine sites in the network, training films for the qualitative and Behavioral Ratings were created. These films were created in order to expose coders to the greatest diversity in child-care experiences within a reasonable period of time.

2. Training Procedures for the Qualitative Ratings and Behavior Scales

a. Qualitative Ratings

Training on the qualitative ratings goes through a progression of steps designed to prepare observers incrementally for their task.

Step 1 - Prior to beginning formal training coders are expected to be extremely knowledgeable of the coding manual. They should be able to define and know the four points of each qualitative scale. They should also be able to supply illustrative examples of each concept. Trainees should be able to pass a written test demonstrating their knowledge of all qualitative items.

Step 2 - The next step of training is to illustrate via multiple taped snippets taken from diverse child-care settings what is meant by each item on the scale. To this end, for the qualitative rating scale, there is a ONE-HOUR VIDEOTAPE illustrating both the positive and negative end of each scale. For example, this tape shows several instances of what we mean by caregiver sensitivity to distress, as well as, several instances of caregiver insensitivity. Multiple exemplars of caregiver positive and negative regard, stimulation of development, and each of the other scales are also provided. Written text

describing each snippet and coding decisions relevant to the snippet are to be provided during training.

Step 3 - The third step of the training consists of learning the cut points for the scales (2-hour training module). This session has trainees view ten 10-minute videotaped segments selected to expose trainees to a wide variety of child-care settings. All of the trainees can view a video segment simultaneously, but they are instructed not to make comments to each other. They are to make written notes as they view the segment. After viewing each segment, trainees independently rate the segment using the qualitative rating scales. Their rating for each scale is noted. Feedback as to the accuracy of the segment ratings, in comparison to the master ratings, is then given. Part of this feedback consists of presenting and reviewing written justifications for each scale, i.e., why we assigned the rating that we did. When the feedback from one segment is completed, trainees then move on to the next 10-minute segment and go through the same process. Because these segments are supposed to familiarize the trainees with decision rules and cut points, high reliability may not be achieved on the scales, particularly in the first of the tapes being reviewed.

Step 4 - During the next four hours of training (divided into two 2-hour sessions), trainees practice making ratings over 44-minute periods, the actual duration of their observations in the field.

Step 5 - Once they return to their sites, trainees should re-play each training tape to practice completing the behavioral and qualitative scales. During practice, trainees' assessments should be done independently, with trainees comparing their ratings and scores with the master ratings only after they have made their own independent judgments. Trainees should carefully study the written justifications and explanations provided for each training tape.

Step 6 - Trainees should then practice doing "live" qualitative ratings at their home site using a variety (types and qualities) of child-care settings. Ideally pairs of observers will make observations that they can compare at the end of 44 minute periods. A minimum of six visits should be completed during this practice period. Questions regarding these scales or coding decisions should be directed to Alison Clarke-Stewart (behavior scales) or Margaret Owen (Qualitative scales).

b. Behavior Scales

Step 1 - Before the training, designated trainees from each site will have memorized coding rules and definitions and will have gone through the pre-training tapes and master codings. Each site director is responsible for assuring that his or her trainees have memorized the manual prior to the training and viewed and discussed these tapes. Trainees should be prepared to discuss the tapes and the behavior scales when they come to the training.

Step 2 - At the training trainees will view the same 10-minute videotaped segments used for the qualitative ratings. In this case, however, trainees will observe for behavior frequencies in 30 second intervals. They will also view tapes that they have not previously seen. These tapes will be stopped and they will mark independently all relevant categories. Immediate feedback on a frame-by-frame basis will be given. After several tapes are scored in this way, trainees will watch and score entire 10-minute segments using the behavior scales. Agreement with the master coders will be determined after the whole segment is scored.

Step 3 - After the trainees have discussed both the Qualitative Ratings and the Behavior Scales they will code one 44-minute tape using both. They will complete the behavior scales for 30 minutes. They will observe and make notes for the qualitative ratings for 10 minutes. Qualitative ratings will

then be made on a full 44-minute segment. Once again, verbal and written feedback in the form of the master coding decisions will be provided.

Step 4 - Back at their home sites, trainees will code 6 more tapes for practice and then practice doing "live" observations at their home site using a variety of child-care settings.

3. Training Procedures for the Child-care HOME

Judith Brisby, from the Arkansas site will conduct the training on the Child-care HOME. Three videotaped HOME interviews will be observed. The first tape will be used to define all items. The second and third tapes will be coded independently by each trainee and then compared to a criterion code from the Arkansas site. Finally, role playing will be used to provide practice on phrasing questions to obtain the necessary data.

4. Training Procedures for the Profile

Because the Profile is designed to capture the quality of the child's child-care environment -- comprehensively defined -- videotapes do not lend themselves as the best method of training. Alternatively, Annette Sibley -- coauthor of the Profile with Martha -- will use direct instruction in the methods, definitions, and coding entailed in this assessment combined with

role playing. In addition, one observer from each site, as a member of a pair, will visit two infant child-care programs over two days, to practice coding the Profile in a live situation. These pairs of coders will compare notes, and any questions that arise will be discussed with observers who are reliable Profile coders (trained to reliability by A. Sibley). No inter-observer reliabilities will be obtained on this measures during the training.

5. Some Words About Getting Used to Being an Observer

There's no question; being an observer is a unique and often frustrating experience. At first, you feel frustrated because there are so many things happening and you have to figure out how to categorize and code them in a limited amount of time. But even after you have the coding system down pat, there will be frustrations because events will occur that you feel are not adequately captured by the coding system. Resign yourself to this fact. You are an imperfect recorder and the observation system is incomplete. We hope, though, that aggregated across different observation cycles, on different days, and with different children, the records you make will lead to a meaningful "big picture."

Another frustration is feeling that what you are observing is not representative of what usually goes on in the setting. It's an atypical day, or your behavior is influencing the

caregiver's or the child's behavior. Again, resign yourself to this limitation of doing in-person observations. There undoubtedly are differences because of your presence. But if you are unobtrusive, inconspicuous, and unthreatening, it is possible for caregivers to relax and children to ignore you and go about their normal routines. Caregivers will probably try to be on their "best behavior" (children won't care), but even if they are, their "best behavior" will be revealing of their typical behavior and will discriminate among individuals. As Frederick Wiseman (documentary film maker extraordinaire) pointed out, when people know they are being filmed (or observed), they tend to behave in the ways they know best and feel most comfortable with, not in ways that are novel and unfamiliar. Atypical events and "bad days" will be hidden in the aggregation of data across cycles, days, and children.

You may also feel frustrated because you are doing the same thing over and over again (the same coding every minute; the same set of cycles and procedures). Avoid this frustration -- a kind of burnout -- by taking an interest in the overall events occurring in the setting, not just focussing on the minute-to-minute coding. Think about the "big picture" of day care quality. Look for unusual occurrences. Take an interest in individual children and caregivers. If you feel you are simply on automatic pilot, discuss this with your project coordinator. You may need a break or some more variety in your work.

Finally, you may feel frustrated because your role as an observer precludes normal interaction with the caregiver or the children during the observation. As an observer, you may look but not touch. At times, this may feel strange, strained, uncomfortable. You may feel that you are acting weird. This is something you'll have to get used to. Try to distance yourself from the ongoing events as if you were watching a movie -- just make sure it's a really interesting movie.

6. Becoming Reliable with the ORCE, Profile, and Child-care HOME

a. ORCE

Four times during each data collection period, criterion videotapes will be independently coded by observers at each site using the ORCE. For the 15 month visits these tests will be March 15-20, 1992; May 15-20, 1992; August 15-20, 1992; October 15-20, 1992, December 1-5 (retest). The tapes used in the December test will be the same ones as in May. Upon completion of their assessment, observers will send their rating sheets to the Data Center where inter-observer reliability will be calculated. The Data Center will compare individual observers' ratings for each scale against those for master coded tapes. The criterion tapes for the Qualitative Ratings are to be scored by Margaret Owen (WI), Jay Belsky (PN), Deborah Vandell (WI) and Anne Stright (WI). Criterion tapes for the behavior scales are

to be scored by Nancy Keefe (UNH), Kathy Masters (UCI) and Alison Clarke-Stewart (U.C.).

In general, when coding from videotapes for the reliability tests, do not code anything you cannot see. Do not infer anything. For example, if a caregiver is smiling but you cannot see if the child is smiling, do not code shared positive affect. (Presumably if you were there, you could move to get a better view.) If the caregiver is off-screen and you can tell that she is talking to the target child, code this (but only if it is obvious.)

If a trainee fails to reach criterion on either the qualitative or behavior scales, the principal investigator and site coordinator for that site will be informed. Feedback as to problem areas will be provided. The trainee then has several weeks to study and prepare for a make-up test. If this second test fails to reach criterion, the observer will not be allowed to make qualitative or behavior ratings.

In addition, at every site, regular "live" reliability assessments should be conducted. Two observers will conduct periodic child-care visits together (these may be for real subjects or for non-subjects) approximately once every two weeks (until they have reached their quota). They will go together to the second of the pair of child care visits and complete either one or two observation cycles the Profile and the HOME. They may compare their scores (a valuable source of continued training) -

but not change them. Both observers' score sheets are then sent to the Data Center so that live reliability scores can be computed from them. For data analyses, the "official" data for a given child are the scores submitted by the child's primary observer (the individual who made the first of the pair of visits). If the subject being rated is NOT a regular study subject this fact must be noted and an ID number assigned using an 8 in the second digit as the ID in place of the hospital code and the last three numbers assigned from a new set of numbers starting with 001.

For sites with two or three raters: The basic principle is that each observer must be paired an equal number of times with the other observer(s) and must be balanced across types of care (center and family). Therefore for two observers the two will rate together in three center based and three family based situations. The center based and family based situations should be alternated. For two raters there will be a total of six pairs of joint ratings.

For sites with three raters each of the pairs (A-B, A-C, and B-C) will rate together in each of two center based sites and two family based sites. (A total of 12 sites will be used; each observer will participate in 8 reliability observations.) Within pairs there should be an alternation of center and family sites.

The order in which pairing should rate is more flexible, but it would be preferred that there be a randomization of pairings over the time period. A typical arrangement would be

AB Center	Rating Time 1
AC Center	Rating Time 2
BC Center	Rating Time 3
AB Family	Rating Time 4
AC Family	Rating time 5
BC Family	Rating time 6
etc.	

b. Profile and End of Visit Scales

For the Profile and End of Visit Scales, two observers will be required to visit 2 centers and 4 home child-care settings. They must score the Profile and End of Visit Scales independently and send their rating sheets to the Data Center. For these measures, only inter-observer, intra-site reliability will be assessed. A second reliability check will be required if any pair of observers at a particular site fail to code reliably on the first check. If this second test fails to reach criterion, this trainee will not be allowed to conduct Profile or End of Visit assessments.

c. HOME

To begin the certification procedure, each site should designate a member of the staff to be the child-care HOME trainer. That person, after studying the manual, should do a child-care visit and administer the child-care HOME (the child-care visit can be done on a pilot family and need not include the

other procedures for the 15-month visit). The entire administration should be videotaped. The designated trainer should submit this videotape, together with a score sheet, to the Little Rock site. Scoring should be based solely on what can be seen on the videotape. Each item on the score sheet should be marked "Yes", "No" or "Did not obtain sufficient information to score". Scoring should be based exclusively on what is obtainable from the videotape, not on observations made during the visit that are not recorded. The Little Rock site will evaluate scoring accuracy and style of administration using the procedures outlined in Section B immediately below. Should the person designated as trainer not meet certification criteria, a "second chance" will be given.

In order to maintain cross-site consistency in administration and scoring, the site trainer should submit new tapes and accompanying score sheets to the Little Rock site every four months, for evaluation.

A certification videotape has been developed by the Little Rock site. Criterion scoring has been developed for each item based on information contained in the videotape (yes, no, insufficient to score). In order to be certified as trained, a visitor must be in agreement with criterion scoring on 41 of 45 items. A second tape will also be made available with criterion scoring provided to serve as a "second chance." In addition, since a single tape cannot include all that one sees in a "real

home visit," the person being certified will accompany a trained home visitor and will administer the HOME in a real setting. The trainer and trainee will independently score the HOME. The trainee must agree with the trainer on 41 of 45 items. Trainees must meet both standards in order to be certified as trained.

The Little Rock site has also developed a checklist of home visitor behaviors to be reviewed in making an overall appraisal of the degree to which families were allowed to reveal who they are and what they do. The appraisal checklist contains eleven items. It covers such issues as whether or not sufficient probing was done to get the information needed to score items, whether the Visitor posed leading or embarrassing questions to the mother, whether the pacing of the interview allowed the mother to act in a normal manner, whether a friendly yet businesslike approach was used, whether a non-judgmental attitude was manifest, etc. It also includes such things as whether the visitor used good listening techniques, encouraged the caregiver to talk about herself and her children rather than simply responding to questions whether "evaluative" type statements were made, whether the pace of the visit was determined more by the family or the visitor, body language, intrusiveness, naturalness, sincerity, respectfulness, projection of comfort, etc. Each behavior on the checklist will be rated on a 5-point scale and an overall score derived. To pass the certification, the Visitor

must attain at least 33 out of 55 points on the rating scale and must receive no ratings of "1" on any of the items.

d. Reliability Updates

In addition to establishing inter-observer reliability prior to beginning the 15-month assessments, additional periodic reliability checks will be made in order to insure that observer or site drift has not occurred. The format and procedures for the subsequent reliability assessments will parallel those of the first test.

e. Reliability and New Personnel

When additional personnel join a site's 15-month child-care assessment team, these observers are expected to follow the same training and reliability procedures as the existing staff. Prior to conducting a child-care assessment, the new personnel must complete the reliability assessment, completed code sheets must be sent to the Data Center for evaluation, and the person must be certified by the Data Center as a reliable observer.

VII. APPENDICES

A. Recruitment Letter for Child-care providers

Dear

As you may already know, (child's name) is taking part in an exciting and important study -- the National Institute of Child Health and Development Study of Early Child Care. He/she has been in the study since he/she was born.

The study aims to learn how the different people, places and events in the lives of young children affect their development. Enclosed is a brief description of the study that tells you more about it.

Because child care provided by adults other than parents is such an important part of children's early experiences these days, we would like to see (child's name) in his/her child-care setting. We would like to come and see (child's name) when he/she is with you. His/her parent(s) have given their permission.

We know you are busy, but we would not disrupt your routine and we would try to work around your schedule. You would not need to do anything special because we were there. We want to see what (child's name) is usually like when he/she is with you. One of our staff would just watch (child's name) doing whatever he/she typically does and ask you some questions about his/her activities and about your background and experiences. Some of these questions can be answered during the visit; others would be answered on a form that he/she would leave for you to fill out.

Your participation in the study will provide valuable information which will help all of us learn more about young children's development.

In appreciation of your help we will pay you \$40.

We will be calling you to tell you more and to answer any questions that you may have about the study. If you want to call us in the meantime, the number is.....

B. Confirmation Letter to Home Care Provider

Dear

Thank you for agreeing to participate in the National Institute of Child Health and Development Study of Early Child Care. It is very important for us to be able to observe (TARGET CHILD) while in your care. Your willingness to let us visit will help us understand how both family care and child care can affect children's development.

As we discussed on the phone, we have scheduled the first of our two visits on _____ from _____ to _____ (approximately). The second visit will be on _____ from _____ to _____ (approximately).

With this letter, we have enclosed a brief description of the study and our visits [FOR SITES THAT NEED TO SEND CONSENT FORM IN ADVANCE: and a copy of the consent form (we will bring an extra when we come)]. When we come for the visit, we will ask you to sign a consent form, assuring you of the confidentiality of our observations.

Once the visits are completed and you send in a questionnaire we will leave with you we will make you a gift of \$40, in appreciation of your time, and, if you are interested, we will send you a report of the findings when the study is completed.

I will call you the day before the first visit to confirm the visit. Please call us if you have any questions before then (phone number).

Yours sincerely
Staff Member
Project Coordinator
Project Director

C. Confirmation Letter to Center Director

Dear

Thank you for agreeing to participate in the National Institute of Child Health and Development Study of Early Child Care. It is very important for us to be able to observe (TARGET CHILD) while in your care. Your willingness to let us visit will help us understand how both family care and child care can affect children's development.

As we discussed on the phone, we have scheduled the first of our two visits on _____ from _____ to _____ (approximately). The second visit will be on _____ from _____ to _____ (approximately). Please talk to the caregivers who take care of (TARGET CHILD) before we come to visit. This is very important.

With this letter, we have enclosed (1) a brief description of the study and our visits (for you to post if you wish) and (2) a questionnaire that we would like you to fill out [FOR SITES THAT NEED TO SEND CONSENT FORM IN ADVANCE: and (3) a copy of the consent form (we will bring an extra when we come)]. When we come for the visit, before we begin our observation, we will ask you and the staff who participate to sign a consent form, assuring you of the confidentiality of our observations.

Once the visits are completed and we will make a gift of \$40 to the center, in appreciation of your time, and, if you are interested, we will send you a report of the findings when the study is completed.

I will call you the day before the visit to ask you some questions about your program. This will save time during the actual visit. Please call us if you have any questions before then (phone number).

Yours sincerely
Staff Member
Project Coordinator
Project Director

D. Description of Study

Children born today will be growing up in a world different from that of their parents. How will growing up in the 1990's affect children's development? To answer this most important question for American's future, the National Institute of Child Health and Human Development has funded the Study of Early Child Care.

The Study of Early Child Care is being conducted at ten different sites in the United States. The main aim of the study is to learn about the variety of people, places, and events that children experience in their early years and the many pathways that lead to healthy development. Aspects of development that are being studied include social relationships, language, intellectual abilities, and health.

Families become involved in the study on a voluntary basis soon after the child's birth. Several times during the three years that the families are involved in the study, the children and their parents are observed and interviewed. Parents are asked to describe their views about child rearing, their feelings about working and parenting, and their perceptions of the child's personality and behavior. Because child care outside the family is also an extremely important setting in which children grow and change, caregivers are asked to participate as well.

Each child in the study is visited in his or her care setting on one or two days, when he or she is 6, 15, 24, and 36 months of age.

During the visits, a staff member observes the child for about 3 hours. He/she tries not to interfere with the usual routine in the child's room. Then, he/she talks to the caregiver(s) briefly about the child's activities and about the caregiver's education and experience. This takes less than an hour of the caregiver's time, and the staff member works around her schedule.

At the end of the visit, he/she leaves some questionnaires for the child's caregiver(s) to fill out. These questionnaires contain questions about the child and about the caregiver's views on child care.

Because we want to see what usually happens when children are in child care, we try to make our visits interfere with the caregiver's routine as little as possible.

The results of this study will not only guide policy makers, but will also be of more immediate use to parents and child-care providers as they engage in the rewarding, but challenging, responsibility of rearing young children.

E. Consent Form

Children born today will be growing up in a world different from that of their parents. How will growing up in the 1990's affect children's development? To answer this most important question for America's future, the National Institute of Child Health and Human Development has funded the Study of Early Child Care.

The University of California - Irvine, is one of 10 sites across the country conducting this study. The purpose of the study is to learn about the variety of people, places, and events that children experience in their early years and how these relate to their development. Children are observed periodically from the time they are one month old until they are 3 years old. Their parents are interviewed about the children's experiences at home and in other settings.

You are caring for one of the children, (name), who is participating in the study. We wish to observe the child while he or she is with you. The child's parent(s) have consented to this visit.

We will try not to interfere too much with your routine. A staff member will come to watch the child's activities for about three hours, on each of two different days. You do not need to do anything differently for the visits. We want to see what usually happens when the child is with you. We want to see the child's typical day -- what he does, who he plays with, how he

acts with you. We will also talk to you about the child's activities and your experiences in looking after children. He/she will ask you some questions about your education and goals. Some of these interviews may be taperecorded. The staff member will also have you fill out forms asking about the infant and about your experiences and your views on childrearing.

Our visit with you will help everyone understand how both care at home and in child care can lead to healthy development.

At the end of our two visits you or your center will be paid \$40 in appreciation for your time.

Your identity will, of course, be kept completely confidential. All of the data we collect will be given a code number and will not be identified by name. Access to the data will be restricted to people who work on the project. We will not be sharing the observations made in your center or home with [the child's] parents. The information we obtain will not be used for any purpose other than research.

You may withdraw your consent for the observation and you may refuse to answer any questions at any time without penalty. [We do not expect that it will ever happen, but we are required by law to report any incidents of serious abuse or neglect that we observe. THIS STATEMENT MAY NOT BE REQUIRED AT ALL SITES -- CHECK]

Signing this form indicates that the study described above has been explained to you, and that you voluntarily consent to

participate. It also indicates that you have had an opportunity to ask questions and understand that future questions you may have about the research or about your rights as a participant in the study will be answered by one of the investigators.

Director/Care provider

Teacher/caregiver

Teacher/caregiver

Research staff member

Date

F. Materials Required for Child-care Assessments

1. Administrative manual for child-care assessment
2. Face sheet for child-care information collected from mother preceding visit
3. Recruitment and confirmation letters
4. Consent form for care provider(s)
5. Return envelopes for questionnaires
6. Director phone interview
7. Director questionnaire
8. ORCE
9. PROFILE observation forms (home and center versions)
10. HOME (for in-home arrangements)
11. Caregiver interviews (father, mother-as-caregiver, home, and center versions [long and short forms])
12. Caregiver questionnaires:
 - Drop off/pick up ("When parent leaves")
 - Modernity ("Ideas about raising")
 - Caregiver stress ("Taking Care")
 - CES-D ("Feelings")
13. Child-care ID Worksheet
14. Mother child-care assessment questionnaire

**G. CONFIDENTIAL WORKSHEET for Assigning Final Child Care
IDs (not to be sent to Data Center)**

Use a sheet like this to record final ID's and match them with actual programs and providers. This form must never be sent to the Data Center and should be kept in the child's locked data file under the 15 month child-care visit at all times, for completion and reference only by the PIs, Site Coordinators, and designated personnel.

In the case of center-based programs, record the name and ID of the director, and then record the names and IDs of all providers observed in this center. For all other arrangements, only names of providers will be recorded. This is the only way we will know when multiple providers were seen in a single arrangement.

When the same provider/center is used by more than one study child, USE THE SAME FINAL ID NUMBERS.

CONFIDENTIAL WORKSHEET CAREGIVER ID'S

Date _____

Child ID _____

Name of Director _____	Temp. ID _____	Perm. ID _____
Name of Center _____	_____	_____
Name(s) of Provider(s) _____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

H. THE NICHD STUDY OF EARLY CHILD CARE

DIRECTOR CHANGE FORM

This form is used to indicate that the center director has changed. The Center/Director ID number, however, will stay the same.

DATE OF DIRECTOR CHANGE

Month	Day	Year
		199
0	0	0
1	1	1
	2	2
	3	3
	4	4
	5	5
	6	6
	7	7
	8	8
	9	9

CENTER/DIRECTOR ID

0	0	0	0	0	0	0
1	1	1	1	1	1	1
2	2	2	2	2	2	2
3	3	3	3	3	3	3
4	4	4	4	4	4	4
5	5	5	5	5	5	5
6	6	6	6	6	6	6
7	7	7	7	7	7	7
8	8	8	8	8	8	8
9	9	9	9	9	9	9

INTERVIEWER ID

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

VIII. CHILD-CARE ASSESSMENTS AT A GLANCE

In a center:

1. Recruit the director and do telephone interview
2. Send information, confirmation letter, and Director Questionnaire
3. Confirm visit the day before the visit
4. Call the morning of the visit to make sure target child is there
5. Do first visit:
 1. See director, get/go over Director Questionnaire
 2. 3 ORCE cycles (or 2)
 3. Profile observation
 4. Typical visit questions
 5. End of Visit ratings
 6. Leave caregiver questionnaires
6. Do second visit:
 1. 1 ORCE cycle (or 2)
 2. Typical visit questions with Caregiver 1
 3. Profile interview with Caregiver 1
 4. Background interview with Caregiver 1
 5. Background interview with Caregiver 2
 6. End of Visit ratings
 7. Pick up caregiver questionnaires

In a daycare home or child's home:

1. Recruit provider
2. Send information and confirmation letter
3. Confirm visit the day before the scheduled visit
4. Call the morning of the visit to make sure the target child is there
5. Do first visit:
 1. Warm-up chat
 2. 3 ORCE cycles (or 2)
 3. Profile observation
 4. Typical visit questions
 5. End of Visit ratings
 6. Leave caregiver questionnaires
5. Do second visit:
 1. 1 ORCE cycle (or 2)
 2. Typical visit questions
 3. HOME interview
 4. Profile interview
 5. Background interview
 6. (Background interview with caregiver 2)
 7. HOME completed
 8. End of Visit ratings
 9. Pick up caregiver questionnaires

Chapter 19

ADMINISTRATION MANUAL FOR THE POST 15-MONTH FOLLOW-UP PHONE CONTACTS (18 & 21-MONTHS)

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Chapter 19

ADMINISTRATION MANUAL FOR THE POST 15-MONTH FOLLOW-UP PHONE CONTACTS (18 & 21-MONTHS)

I. INTRODUCTION

This chapter provides specific information about the questions included in the phone updates to be done at 18 and 21-months. In addition, it will serve as the archival description of the way in which phone-interview data were collected.

Any questions concerning these procedures should be addressed to Marion O'Brien or Aletha Huston at the Kansas site and Kaye Fendt at the Data Coordinating Center.

II. INSTRUCTIONS FOR CALLING

It is crucial for sites to maintain regular contact with all families participating in the NICHD Study of Early Child Care. If a mother is not contacted at one of the phone update points, the chance of losing the family from the study increases. Therefore, it is important for sites to make as many attempts as necessary to reach the mother. If the family has a phone but the mother has not been contacted in the first three days of regular attempts, efforts should be increased to include evening and weekend calls. If the mother is not contacted by the end of the first week of attempts, begin to use the procedures outlined in

Section II.E, What To Do if You Cannot Reach the Family by Phone (page 5).

The child's mother must be contacted and interviewed in all cases. The only exceptions to this rule are situations where the mother is out of phone range for some unusual reason (serving in the military, for example) and will not return until after the data-collection window is closed. In this case, conduct the interview with the child's father if possible, or, if there is no father involved, with the child's primary caregiver. Indicate on the interview face sheet the relationship of the person who has been interviewed (0 = Mother, 1 = Father, 2 = Grandparent, 3 = Other Relative (includes sibling), 4 = Primary Caregiver, 5 = Support Child-care Provider, 6 = Child-care Provider (no hierarchical designation; use in instances where all classroom teachers are of equal status), 7 = Director (only in centers). If the mother is out of town but reachable by phone, she should be contacted wherever she is. If the mother is unreachable for a short period of time (e.g., in the hospital), arrange to call her back when she has returned home if this will be within the window for data collection.

If the mother is no longer living in the same household with the child, determine who has primary custody of the child and who the child's primary caregiver is. The legal guardian of the child should then be contacted and informed about the study. If he or she is interested in continuing to participate, a home visit should be made to obtain informed consent. At this time,

the information on the update can also be obtained. Code relationship as above.

A. When to Make the Calls

Families should be contacted within a 3-week window, from 1 week before the child's 18- and 21-month birthday to 2 weeks after that birthday. Begin making calls at the beginning of the data-collection window (i.e., one week before the child's birthday) in order to complete as many contacts as possible within one week (plus or minus) of the child's birthday. The extra week is allotted for unusual situations where mothers are especially difficult to contact.

B. What to Do if You Cannot Complete the Interview in a Single Call

Families with young children have to cope with a lot of interruptions. If the interview cannot be completed at one time, arrange a specific time to call back before the end of the following day. Thus, the second call should be within 36 hours of the first call. If this is possible, the second interview can proceed from the point where the first interview left off. If more than 36 hours elapse between calls, begin the interview again, from the beginning. Say something like, "I'm going to begin at the beginning to be sure we haven't forgotten anything."

C. How to Leave a Message

If you reach the family's home but are unable to talk with the mother, leave a specific message, including a time when you will call back. A suggested message to leave with another person follows.

"This is YOUR NAME from the NICHD Study of Early Child Care at the University of _____. We visited with MOTHER'S NAME about ____ months ago, and I am calling to see how she and Child are doing. She can reach me at PHONE NUMBER and DAYS/TIMES. I know she's very busy so I'll try to reach her again. Do you know of a good time for me to call?
(Record day and time.) Thank you."

D. An Alternative Message for an Answering Machine

"This is YOUR NAME from the NICHD Study of Early Child Care at the University of _____ calling for MOTHER'S NAME. We visited with you in MONTH, and I am calling to see how you and Child are doing. You can reach me at PHONE NUMBER and DAYS/TIMES, and I'll call back DAY/TIME. Thanks."

E. What to Do if You Cannot Reach the Family by Phone

If you are unable to reach the family by telephone because they do not have a phone, their phone is disconnected, their number has been changed to an unlisted one, or after a week of trying at all times of day and evening you have not contacted the

family, special efforts must be made to reach the mother. The following steps are recommended:

1. Call work numbers if available. Unless parents have explicitly asked you not to call them at work, call the work numbers for either or both parents to arrange a convenient time to conduct the interview.

2. Make a home visit. When possible, the most effective approach to contacting a hard-to-reach family is for a project staff member who is acquainted with the mother to stop by the family's home. Often, people will not have moved if their phones are disconnected or changed to an unlisted number. The home visit should always be carried out by someone who has met the family, preferably someone who has been to the home before (one of the home visitors, for example). If the family has no phone, the interview can be carried out in person, or an alternate arrangement can be made for the interviewer to collect the information from the mother.

If no one is at home but it looks as though the mother still lives there, leave a letter or card asking her to contact the project office. Be sure to let her know she can call collect.

3. Call the family's alternate contacts. Alternative phone numbers, which are updated at each contact point, are useful primarily for obtaining new addresses and phone numbers for study families. Leaving messages at the homes of alternative contacts is generally

not productive, although it can be tried. Asking alternative contacts to go and get the mother while you wait on the telephone is an imposition, and is not recommended. If the alternative contact can provide a new phone number or address, follow up on that by calling or making a home visit.

4. Send a letter with the project phone number and a return postcard to the family's last-known address. (A sample letter is included in Appendix B.) This prompt is often enough to encourage mothers to call you, or to send you their new address or phone number. Then you can follow up with a phone call or home visit. Be sure to let the mother know she can call you collect. Mark the envelope Address Correction Requested in order to receive a new address.

5. Call Directory Information in surrounding areas. The family may have moved nearby and still have a published phone number.

6. Check with the post office. Provide the family's last known address to the post office and ask for the newest address for the family. The post office will charge \$1.00 per name to give the most recent forwarding address.

7. Call the child-care provider who was interviewed at the last data collection point. If the child is still in that provider's care, ask if you can deliver a message to the family through the provider. If so, take or send a

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letter with return postcard for the provider to give to the family.

F. What to Do if the Family Is Not Contacted Within the Three-Week Window

If the above efforts are not successful and the family has not been contacted before the 3 weeks are up, continue to follow whatever leads you have to contact the family. A second call to alternate contacts is acceptable, but there is nothing to be gained by pestering them. Our guarantees of confidentiality prohibit us from contacting neighbors or others whose names have not been provided to us by the family. It is more important to protect the confidentiality of our subjects than to find every family at every contact point.

When all leads are exhausted, give up the effort until the next point of contact. Do not drop the family from the study because of missed phone contacts.

G. What to Do if the Mother Says She No Longer Wishes to Participate in the Study

When a mother tells you she wishes to withdraw from participation, ask, "If you don't mind, can you tell me why you don't want to continue?" Very politely, and without being insistent or coercive, try to reassure the mother.

1. If she says she's too busy, having another child, going back to work, or just feeling overwhelmed, say

"Yes, you must be really busy. Especially with all these new demands on your time and energy. We do our best to make things as easy as possible for you. There are no more than two visits per year, and we like to schedule them at your convenience. We can work around the other demands on your time."

2. If she says her husband/partner doesn't want her to continue, say

"What does he seem to be concerned about?"

Then listen. Acknowledge the mother's concerns. When she is done and leaves time for you, provide supportive information, and ask

"Would you like me or SITE P.I. to call him and talk with him about our study? We would be more than happy to speak with him."

Arrange a time to call if this would be helpful.

3. If mother continues to say she wants to withdraw, say,

"I'm sorry you feel you cannot continue. We would very much like Child to have the opportunity to participate in what we think is a very important study. But I certainly

understand your feelings. If you change your mind, please call us. And feel free to call if there's any other way we can help you."

Fill out the form for recording dropouts and send it to the Data Center.

III. RECORDING CALLS

The form, Record of Calls, is for use at the sites to keep track of all attempts to reach a mother. Every time the caller attempts to contact the mother, the date and time should be recorded and the result coded according to the codes listed at the bottom of the sheet. The interviewer's code or initials should also be marked on this sheet so that if more than one caller is trying to reach the mother, each one will know who has already left messages with the family. Any special situations should also be recorded on the reverse of this form. The Record of Calls is retained at the site in the family's confidential folder.

IV. FORMAT OF THE PHONE UPDATE INTERVIEW

Every Interviewer should become thoroughly familiar with the format, layout, and questions of the interview. Because of the many different family situations we expect to encounter during this study, the questions have been written to try to cover a great variety of responses. It is not possible, however, for the questions to suit every situation perfectly. At times

the Interviewer must adapt a question slightly so as not to appear insensitive to a mother.

Within each section of the interview, there are a number of choice points when the Interviewer must skip over particular questions or sets of questions because they are not relevant to a particular situation. It is important that each caller be completely at ease with these choice points so that the interview can proceed smoothly and the mother be unaware of the many coding decisions and question selection decisions the Interviewer is making.

The conventions followed in this interview protocol are:

1. The directions to the Interviewer that are not intended to be read to the mother are printed in ALL CAPITAL LETTERS. The questions and comments to be read to mothers are printed in upper- and lower-case type.
2. The Interviewer is expected to continue to the next question unless instructed otherwise by a GO TO or choice point instruction.
3. Questions that must fit more than one situation are worded so that the choices between two wordings are in parentheses. Example: Last time we talked you (were/were not) going to school. The Interviewer is expected to choose the correct wording for this particular situation, not read both options. This requires that the Interviewer have the questions clearly in mind, understand the different possible

situations to which they refer, and have information about the family available.

4. Questions in which a person's name (or other specific information) is to be used indicate the missing information in capital letters, as, for example: Has Child had any ear infections? The question should be read as, Has Joshua had any ear infections?

V. MARKING THE FORMS

The mark-sense forms used for the interview must be filled in carefully. Use a #2 pencil and be sure to blacken the entire space to indicate the mother's response. Whenever there are 2 columns of numbers, as for month and day, for example, mark both columns. If your response requires only one digit, mark 0 in the first column.

For example, to record a date of February, 1989:

MONTH	YEAR
<u>02</u>	<u>1989</u>
- 0	0 0
1 1	1 1
2 -	2 2
3 3	3 3
4 4	4 4
5 5	5 5
6 6	6 6
7 7	7 7
8 8	- 8
9 9	9 -

The blanks above the columns are for your convenience in recording mothers' responses. Often it will be quicker to simply write in the response and then darken the mark-sense spaces later. This is especially true for complex questions that have

several sets of responses, such as the household composition information.

In response to some questions, a mother may give you additional information that is not coded but that you want to record in order to demonstrate that what she wants to tell you is important, and also to help build rapport with the mother. You can write such information on the forms as long as you do not write over the mark-sense spaces. Try to keep your notes to the left side of the page.

VI. INTERVIEW SCRIPT

The interview data forms contain all of the introductory information you need to explain to the mother what is going to happen next. They should be read the way they are written. At the beginning of the interview, you may also find it helpful to add some informal conversation with the mother to make her comfortable, but do not spend too much time chatting before getting down to work. The mother appreciates your friendliness but will also appreciate not being kept on the phone too long.

Once you begin the questions, they must be read exactly as they are written. The only exception to this rule is the occasional situation where the information requested is obvious or already known to the Interviewer. In these cases, the Interviewer may reword the question as a statement, confirming with the mother that the information obtained previously is accurate.

Mothers have different ways of responding to interview questions. Some are very precise and specific, but others tend to give vague responses or answer in general ways that are not codable. You can encourage mothers to be more specific by enlisting them as partners in the process of data collection.

For example, if a mother responds to the question,

"How many hours a week do you work?"

by saying

"15 or 20 hours"

you can say,

"I need to record a specific number of hours. Please give me your best estimate of the number of hours you work in a typical week."

The next time the mother responds with a range of numbers instead of a single answer, follow the same procedure. Usually after two reminders, mothers will understand the requirements of the interview and begin to give you codable responses without prompting.

VII. INTERVIEWING TECHNIQUES

Be sure to read all questions exactly as they are worded. If the wording seems awkward to you, practice saying the questions aloud until you feel comfortable with them.

On some occasions, mothers may volunteer information during one part of the interview that you will ask them later. Remember what they have said, but do not flip through the interview pages to record that information. Instead, when you come to the

relevant section, confirm the information you have received and ask, *"Is there anything else?"* For example, if the mother tells you right away that she's starting back to work next week, when you come to Question 12, *"Are you working for pay now?"* You can say something like, *"You said you're starting work next week. Right now are you working for pay?"* Whenever you are confirming information with the mother, use the wording of the question as written to the greatest extent possible. It is essential that you cover the content of every question. Do not assume information without confirming it, even if it seems self-evident.

Because the interview cannot exactly fit every possible situation for all the mothers in the study, there will at times be questions that seem to you inappropriate. In these unusual cases, you can say something like, *"The next question asks..."* Done politely and without belittling the question, this approach lets the mother know you are attuned to her individual situation, but also that you have a job to do and you take it seriously.

Do not interpret or reword questions. If a mother asks for clarification of a question or word, try repeating the question, perhaps with a slight change in intonation. Sometimes mothers may ask the meaning of a question that has a set of multiple choice answers. In this case, you can read her the options so she can select one of the choices.

VIII. FACE SHEET

The face sheet for the telephone contact is for use by the project staff at each site to help keep track of the information needed in the interview. This sheet is not to be sent to the Data Center.

Before calling, fill in all the indicated information on the face sheet, which is Page 2 of the interview forms, and also fill in the household information on Pages 5 and 6. Use the information collected at the most recent contact to fill in these pages.

During the call, you will get information on changes in addresses, phone numbers, and contact persons. Write this new information on the face sheet. Changes in other information on Page 2 obtained during the interview will be recorded on the interview forms themselves.

A second face sheet in mark-sense format is attached to the interview form. At the completion of the interview, fill in this form completely, with date of interview, interviewer's ID number, subject's ID number and relationship code, and child's age in months.

Once the interview is completed, separate the site face sheet and the record of calls from the interview itself and file them in the family's confidential folder. Have the interview forms checked by the site coordinator or her designee before they are sent to the Data Coordinating Center.

IX. THE INTERVIEW FORMS

This section of the manual provides specific information about the questions included on the phone update interview. Callers should read it through each day before they begin making calls to be sure they are thoroughly familiar with all coding rules and with the format of all questions and answers.

A. Part 1: Household Data

Question 1

You will have listed all the household members reported at the last contact before calling. The purpose of this question is to track changes in the child's household composition. Read to the mother the first names of the people you have listed, and ask if there are any changes. For people still present, fill in a 1 in the Change Code column. For anyone who is no longer present, fill in a 2 in the Change Code column.

If the child's father or another member of the household is temporarily away from home (for example, in military service), he or she should still be coded as part of the household. If this applies to the child's father, conduct the remainder of the interview considering him to live in the household.

If new people are added to the household, record their first name, relationship to the child, and relationship to the mother as she describes them to you. Record their age and sex and a 3 in the Change Code column. Assign the relationship codes listed above the grid after the interview.

Try to remember who lives in the household as you continue through the interview, because it will help guide whether to ask certain questions and the interpretation of some of the responses you receive.

Questions 2 and 3

Ask these only if the child's father has left the household since the last contact (that is, he has a change code of 2 for Question 1). If he had already left by the last contact, this information was obtained at a prior interview.

Question 2 is intended to establish the mother's legal and emotional relationship to the child's father. Response 1: Separated means that the mother is now married to the child's father but they are not currently living together by choice. Use these follow-up questions if the mother's initial response is incomplete:

Are you now married to FATHER?

Were you ever married?

Would you say you still have a romantic relationship?

B. Part 2: Health of Child and Mother

The time period included for all these questions is the interval since the last contact (about 3 months).

Question 4

Read the four choices and record mother's response. Do not try to interpret her answer for her, even if you think two runny

noses are not a good reason to rate the child's health as "fair." You can add your notes about the mother's response, but you must code the answer she gives you.

Question 6

Mother should have received a positive diagnosis of "ear infection" from a physician or health professional to code 6a as "yes." Describe the medicine in her words. If she does not know the technical term for it, record what she does know (e.g., "some kind of antibiotic," "pink liquid that Child took for 10 days").

Follow-up with 6b only if the child has had any ear infections. If the mother says she doesn't know or the doctor didn't check, or she hasn't been back to the doctor yet, record "no."

Questions 9 and 10

When you ask the mother how many times the child has been to the doctor, she will often begin to tell you the reasons. You can move immediately to Question 10 and walk her through the responses. To slow her down, giving you time to record, you can simply repeat what she is saying and confirm it. Your conversation might sound like this:

I: *"How many times?"*

M: *"Well, we went in early March for shots and then he got a bad cough..."*

I: (Turn to Question 10.) "So he had a routine check up and immunizations in March?" (Mark Response 1.)

M: "Yes, and then he got sick."

I: "Was this a follow-up of an earlier problem or chronic condition?"

M: "No, this was the first time he'd been sick."

I: "So you took him to the doctor for a cough. What did the doctor say was wrong?" (Mark Response 3.)

M: "He had bronchitis."

I: "Was Kevin hospitalized for that?"

M: "No, but he was sick for a week."

I: "Has Kevin been to the doctor for anything else?"

M: "No, those are the only two times."

I: (Record "02" under Question 9.)

Repeating and confirming the information with the mother allows you to obtain accurate information in a conversational manner.

Item 4b lists the conditions which could result from an injury. Because this is a phone call and card 13 can not be handed to the mother, read the list of conditions to her if she responds "Yes" to injury in item 4.

Question 11

Read the four choices to the mother and get her description of her overall health. Do not try to interpret her answer, even if you think differently than she does.

If mother begins talking about her health problems, respond pleasantly and as quickly as you can without being rude. Do give the troubled mother a chance to complain or explain, but do not encourage long descriptions of health problems. Often, a sympathetic "I'm sorry to hear that," followed immediately by the next question, will get the conversation back on track.

Do record health problems described by the mother as these may be important in her ability to (a) work and (b) provide care for her child. Also, it will help build rapport with the mother if you ask specific questions about her health the next time you call her.

C. Part 3: Mother's Employment and School

An open-ended question is asked at the beginning for your information only, not for coding of occupation. It allows you to find out the kind of work the mother perceives herself as doing, so that you can talk intelligently with her about it. This is an opportunity to find out if the mother considers herself a mother and homemaker, if she has more than one job, if she is self-employed, or if her view of her job status has recently changed. This information can guide you in how to ask questions and how to interpret the responses, as well as where you need to probe more fully to get a complete picture. You will get a more specific description of the mother's occupational classification beginning with Question 17.

Question 13

A mother is working for pay now if she is employed for pay, either in or out of the home. This does not include the mother who is on leave and therefore still employed but not currently actually working. If a professional woman is officially on leave, she is not counted as working now even though she may spend some of her time at home doing professional things. Because we are updating employment information every 3 months, we keep track of the mother's return to work and any changes in her job status as the study progresses.

Question 14

This is intended to get current work situation, as of the day you interview the mother. If you are talking to her on Friday and she is starting work Monday, she is not now working.

If the mother says she works "full-time", explain, "I need to get a specific number of hours. Please give me your best estimate of how many hours a week you work." Give the mother an opportunity to tell you what her actual work hours are.

If she works a variable number of hours, record the average number of hours per week, according to the mother.

Question 15

Count only hours at home for which she is paid, and, if she is a salaried professional, hours that are directly related to her paid employment. If the number of hours varies, ask for the "most typical situation" in the mother's opinion.

Question 16

If mother's work falls within one of the time periods listed in Question 16, record that period even if she does not work the whole time. For example, if she works from 1 to 5 p.m., record (1) Daytime. If she regularly works hours that overlap the intervals listed, record both times. For example, if she works a 12-hour nursing shift from 11 a.m. to 11 p.m., record both (1) Daytime and (2) Evenings.

Similarly, if a mother works days and evenings on a regular basis because of having two jobs, record both. If a mother works days one week and evenings the next, record (4) Times vary.

Question 17

Information on the mother's previous job status will be recorded on the interview face sheet. The same job means just that -- the exact position held with the same employer. A different job title with the same employer (resulting from a promotion or other change in duties) is recorded as a change. If she has the same position title and the same employer but a shift in place of work (for example, a teacher who moves to a different school in the same system), this is not a change.

If mother currently has one job, record Y or N under Job 1. If she has one job now, but had two jobs before, record Y for the job she now has and had previously (Job 1 or 2) and N for the job she used to have but no longer has. If she did not have a second job before, leave Job 2 blank.

If mother has two jobs now and one of them is different from her earlier employment, record Y for the job that is the same and N for the one that is not.

Continue to record Job 1 and/or Job 2 information under those columns throughout this section.

Question 19

Ask this question only if the mother's job title (Question 18) is not clear to you. Thus, if the mother says she is an insurance underwriter, you do not have to ask Question 19.

Question 21

This question is asked only if the name of the employer (Question 20) is not self-explanatory. If the employer is well-known to you, do not ask Question 21.

Question 22

Use the occupation coding definitions (Appendix A) to choose a category. Verify your coding with mother only if you are not entirely clear on the nature of her occupation. In that case, find an entry on the occupation coding chart that you think fits her job, and ask the mother if she agrees with your judgment. Do not ask her the category. For example, if you have learned that the mother works as a nurse, you need to find out if she is an RN (coded under Professional) or an LPN (coded under Technicians).

Questions 23 and 24

These questions are intended to complete the mother's work history since the last contact. The mother may have continued one job, quit a second job, and started a new job. You found out in Questions 17 and 18 whether she was still in the same job(s). Now you want to find out when she started any job that is new since the last contact, and when she stopped working at any job that has ended since the last contact.

On Question 23, record the most recent date she began a new job. Note this applies only to jobs begun since the last contact or jobs that were not recorded in the last contact. Keep Job 1 and Job 2 consistent with the previous interview. For example, record the dates under the Job 1 column if the mother has stopped working at the job previously recorded as Job 1 and started a new job. Keep these labels consistent even if the job previously recorded as Job 2 is now her primary job.

On Question 24, record a termination date for any job at which the mother is not currently working or on leave, even if she expects to go back (e.g., has been temporarily laid off). Record the date under Job 1 if she is not presently working at any job, but said yes to Question 13 (i.e., that she had worked for pay since the last contact).

Question 25

If you already know the mother is pregnant or has had another child, confirm that this is why she stopped work.

Otherwise, read the first five responses to the mother. Record Other only if none of these four fits her situation.

Mother's health includes her mental health. For example, if mother says she experienced too much worry about the child, emotional tension, or exhaustion, code Mother's health.

Child's health includes behavioral reactions of the child in child care, such as the mother's belief that the child was upset, unhappy, showing signs of distress if these have been manifested in physical symptoms such as stomach distress, sleep problems, or eating problems.

Childcare problems are the "external" problems of finding appropriate and affordable child care. They may include lack of available care, care that is too expensive or inconvenient, care that is unreliable or of poor quality, distrust of sitters, and the like.

Employer reasons include any reasons involving employers' actions or attitudes. For example, a mother may be laid off or fired, or the employer may have been inflexible about her need to take time off for family or personal reasons.

If the mother says something like she just changed her mind, or she thought she would be able to handle working and caring for her child but found out she couldn't, ask her if any of the listed reasons fits her situation. If not, record her reason under Other.

Question 26

Information on whether the mother was previously attending school will be recorded on the interview face sheet.

"Going to school" is defined as enrolled in an educational program that normally leads to a degree, certificate, diploma, or the attainment of job-related skills. Taking an evening course just for the fun of it does not count as going to school, nor does taking a parenting class offered by the local hospital. On the other hand, if the mother is taking an evening course on computers because she is planning to start a word processing business at home, then it should be recorded. Similarly, if the mother is enrolled in something like 6 credit hours at the local community college, she should be counted as attending school even if she is not officially in a degree program.

Knowing what kind of school the mother is or was attending is important for later questions and also for building and maintaining rapport with the mother. Although this information will not be coded into the data base, it will be important for you to know in future conversations with the mother.

Question 28

The intent of this question is to find out how much time the mother was spending doing school work -- time in class plus time spent on school-related work. As a general rule, use the following coding rules for counting hours in school. For high school or vocational school where people enter a building and attend classes for a portion of each day, count the number of

actual school hours (e.g., 8:30 to 3:30 for five days a week would count as 35 hours). For community college, college, or graduate school, count the number of credit hours in which people are enrolled, multiplied by 3, to get an index of involvement with school (e.g., a student enrolled in 12 hours -- which is considered a full-time load -- would be recorded as going to school for 36 hours; a student enrolled for one course of 3 hours credit would be recorded as going to school for 9 hours). Although different types of schools will vary somewhat in their time requirements, these calculations will provide a general index of time spent.

Question 29

If mother's school hours fall within one of the time periods listed in Question 29, record that period even if she does not go to school the whole time. For example, if she attends school from 1 to 5 p.m., record (1) Daytime. If she regularly attends school during hours that overlap the intervals listed, record both times. For example, if she is in school from noon to 7 p.m., record both (1) Daytime and (2) Evening.

Questions 30 and 31

These questions are intended to complete the mother's school history since the last contact. The mother may have started and stopped going to school during the past 3 months.

D. Part 4: Husband/Partner Employment and School

If a husband or partner lives with the mother, get this information about him. We will not inquire about nonresident fathers or partners on these updates, although we will do so during home visit interviews. If the husband/partner is temporarily away from the family (e.g., in the military), do ask these questions.

Information on the husband/partner's job situation will be recorded on the interview face sheet before the call is made. An open-ended question is asked at the beginning of this section for the Interviewer's information only. It allows you to probe for whether the husband/partner has more than one job, is away from home temporarily, or is self-employed. More specific information about the husband/partner's job classification is obtained beginning with Question 35.

Question 33

The response to Question 33 should include total hours working at all jobs. The following questions also concern all jobs. The issue we are interested in is how much time he is available to help with child care and other home responsibilities.

If the mother replies that he works "full-time", explain the kind of response needed. For example, say, "I need to get a specific number of hours. Please give me your best estimate of how many hours a week he works." Give the mother an opportunity to tell you what his actual work hours are. If the mother gives

you fractions of hours (as 37½ hours) round to the nearest whole number, counting 0.5 or more as the next higher number and anything less than 0.5 as the next lower number.

If the husband/partner works a variable number of hours, record the average number of hours per week he has worked for the past month. Work at home for which he is paid should be included. If he is a professional who regularly brings work home, the hours spent on work that is part of his paid employment should be counted.

If the mother reports that the husband/partner is away from home overnight on a regular basis, or that he often has job assignments that take him away from home for periods of several days or weeks at once, code Question 33 as 99.

Question 34

Even if the mother has told you his employment situation has not changed, confirm with her the husband/partner's job title. At 18-months, prior partner employment information is obtained from the 12-month phone call.

Questions 35 and 36

If the husband/partner has a new job and you know that job title from the mother's response to the open-ended question about employment, confirm it here. "And you told me HUSBAND/PARTNER was an English teacher." If the job title was not clear from the earlier conversation, ask, "What is his position title?"

In this section, we are collecting information about the husband's/partner's current job situation, as of the day of the interview. We will update this information every 3 months during the course of the study. If the mother reports that the husband's/partner's current situation is very unusual (for example, he is working as a melon weeder for the summer while looking for a job as a corporate lawyer), assure her that we will learn about the job changes periodically and record information about current employment. If, on the other hand, the father has a temporary summer job because he is a schoolteacher, record information about the teaching job, if the mother defines that as his primary job. Do not collect information on more than one job. Let the mother define which job is primary, and collect information only on that job.

Question 36 needs to be asked only if the position title (Question 35) is not self-explanatory. If the position title is Elementary School Teacher, for example, you can skip Question 36. But if the mother says her husband is a Retrofit Specialist, you should probe for a more understandable description of his job.

Questions 37 and 38

Question 38 should be asked only if the response to Question 37 is not self-explanatory. If the employer is well-known to you, do not ask Question 38.

Question 39

Use the occupation coding definitions provided (Appendix A) to code occupational category. Verify your coding with the mother only if you are unsure of the husband's/partner's occupation. In that case, find an entry on the occupation coding chart that you think fits his job, and ask the mother if she agrees with your judgment. Do not ask her the category. For example, if you have found that the father works in a lab for an environmental consulting firm but the mother is vague about his duties, you look on the occupation coding chart and find two possibilities. Ask "Would you describe him as a biological or life scientist (Professional category) or a biological technician (Technician category)?"

Question 40

"Going to School" is defined as enrolled in an educational program that normally leads to a degree, certificate, diploma, or the attainment of job-related skills. Taking an evening course in conversational Spanish just for the fun of it does not count as going to school, nor does a parenting class offered by the local hospital. On the other hand, if the child's father is required by his employer to take the Spanish class because he is going to attend a sales conference in Chile, then it should be recorded.

Question 41

The intent of this question is to find out how much time the mother's husband or partner spends doing school work -- time in class plus time spent on school-related work. As a general rule, use the following coding rules for counting hours in school. For high school or vocational school where people enter a building and attend classes for a portion of each day, count the number of actual school hours (e.g., 8:30 to 3:30 for five days a week would count as 35 hours). For community college, college, or graduate school, count the number of credit hours in which people are enrolled, multiplied by 3, to get an index of involvement with school (e.g., a student enrolled in 12 hours -- which is considered a full-time load -- would be recorded as going to school for 36 hours; a student enrolled for one course of 3 hours credit would be recorded as going to school for 9 hours). Although different types of schools will vary somewhat in their time requirements, these calculations will provide a general index of time spent.

E. Part 5: Child Care

Coding Child Care Arrangements

Mothers will answer the questions about child care arrangements with more conventional descriptions (childsitter, nanny, etc.). The responses on the interview form are not intended to be read to parents. Rather, they are for your use in coding the type of arrangement the parents have made for child care. Thus, if the mother says they have found a sitter, you

will need to ask if the sitter is a relative and whether he or she comes into their home or they take the child to the sitter's home.

Be sure to code all arrangements, even if some of them are informal, such as the child's father staying home until 9:00 every morning. Although many mothers will not think of this as a child-care "arrangement", it is to us. Backup arrangements that are not regularly scheduled but available for emergencies are not recorded. Use Arr. 1 for the arrangement used for the most hours, Arr. 2 for the next, and Arr. 3 for the third. Do not code more than 3 arrangements.

Examples of probe questions to ask:

Mother's Response

Query

My neighbor is caring for Child.

- 1) Is your neighbor related to you?
- 2) IF NO, code (a) 6
- 3) IF YES, What relation?
- 4) Is Child cared for at your neighbor's house?
- 5) IF YES, code (b) 2
- 6) IF NO, Where is Child cared for?
- 7) Does your neighbor care for Child during all the hours you work?
- 8) IF NO, What other child care arrangement do you use?

My church has a nursery that I use.

- 1) Who cares for children in the nursery?
- 2) Is the nursery open during all the hours you work?
- 3) IF NO, What other child care arrangement do you use?

My husband is taking time off when I'm working.

- 1) Does he care for Child at home?
- 2) Is he able to care for Child during all the hours you work?
- 3) IF NO, What other child care arrangement do you use.

I've hired a nanny.

- 1) This is someone who comes to your home to care for Child?
- 2) IF NO, Where is Child cared for?
- 3) Is this person related to you?
- 4) IF YES, What relation?

Question 42

The purpose of this section is to get information about all the family's regular child-care arrangements. Regular means that the mother has some standing arrangement with another person to care for the child at a specified time. This may include short periods of child-sitting. For example, if the mother has a regular evening or Saturday afternoon when her husband/partner is expected to be responsible for the child, this is a regular arrangement. Also, if the mother leaves the child with her mother every Thursday afternoon, or expects an older sibling to be responsible for the child from 4 to 5 every day, these count as regular arrangements. If she occasionally hires a sitter to go out in the evening, this is not a regular arrangement. Back-up arrangements, or those set up in case of illness, do not count as regular arrangements.

Questions 43

If mother has responded to Question 42 with NO but responds to Question 43 by telling you that the child's father is helping her with child care while she works, go back to Question 42 and score YES. You may then restate Question 44 as a statement:

44.(a) Child's father will care for Child. (b) "Where will they be?"

Question 44

Code all current arrangements the mother is using. If she begins to tell you about future plans, explain that we will be gathering information on changes in child-care at later interview points, but right now we want to know about her current child-care situation.

Questions 45 and 46

The purpose of these questions is to find out how many other children are usually present when the child is in the care setting, and how many regular caregivers the child has. In a day-care center record the number of children in the child's group or classroom, not the number in the whole center. In both centers and homes, the number may change during the day. Ask the mother for the typical number present during the majority of the time the child is in the setting. For example, if three kindergarten children are cared for by the child's caregiver from 4 p.m. on, but the target child is cared for from 8 to 5, do not count these children as part of the typical group. Base the

typical group on the current situation; group sizes will also change seasonally.

In counting caregivers, ask the mother for the number of different people who supervise the children on a regular basis. For example, if the child's group has a head teacher who is present all day, two assistants in the morning and two different assistants in the afternoon, the number of people supervising the children is 5. If a home child-care provider has a teenager or another adult who regularly assists with the children, and the caregiver's husband is in charge every day after 4:30, the number of people supervising the children is 3.

Questions 47 and 48

These questions are intended to get at the pattern of child care as well as the total number of hours. Thirty hours divided over 3 days is a different experience for the child than 30 hours divided over 5 days. In cases where the child's schedule changes from week to week, ask mother for the "most typical" situation in her opinion. We will obtain more detailed information about schedules when we do child-care visits. If the word "arrangement" is awkward for the situation of the family you are interviewing, reword Question 69 to say, for example, "*How many hours a week is CHILD cared for by your mother?*"

Question 49

For responses in weeks or parts of months, round to the nearest month. If the mother says 16½ months, ask her if it was

closer to the child's 16 month or 17 month birthday. You can also get the date of enrollment and calculate the child's age, confirming the age in months with the mother.

Question 50

If mother volunteers a codable response immediately, record that. If not, say, "Which of these reasons was the most important? I'll read you the list; there are 10 choices. Cost? Convenient hours? Convenient location? Quality of care provider? Quality of environment and equipment? Quality of program? Preference for relative to provide care? Preference for home environment? Preference for center environment? Availability?" Record only one response. If mother says several were important, say, "Which would you say was the most important reason?" If you begin reading the list, try - politely - to get through the entire list, even after the mother picks one. Then confirm that her initial response was the most important reason.

Question 51 to 58

These questions are intended to get a complete history of child care used, even arrangements that were used only briefly. Ask Question 51 of all mothers, even those who are not now using child care and who were not using child care at the last contact. At 18-months, the last contact would be the 13-month phone call for child care information. Follow the same coding rules for Questions 52 to 58 as described above for coding current arrangements.

Question 59

This is a question about child care, not about health. The intent is to find out if parents have had to modify their child-care arrangements because of illness, or have been concerned about the special needs of a sick child.

Question 60

When a child is sick, mothers often have to piece together a patchwork of care. Record one or two emergency arrangements the mother made.

Question 61

A "day" of work means a significant amount of work. Code Yes if one parent missed a half day or an important work obligation, such as an important meeting or appointment.

Question 62

Read the list of possible problems if the mother does not immediately volunteer a codable response.

Question 63

The purpose of this question is to identify any important events impinging on the mother or the family and give the mother a chance to talk about anything that's important to her that has not been covered in the interview. Important events can be happy or sad. Record whatever the mother says is important to her.

X. DEBRIEFING

Follow the script as written, being sure to give the mother a chance to ask any questions she may have. It is a good idea to make a note of any questions and what your response is, and to check with your Site Coordinator and/or P.I. to be sure all staff members are following the same procedures. If you are at all unsure about the answer to a question, do not try to answer it. Instead, tell the mother you will find out and call her back. Talk to the Site Coordinator and/or P.I. and arrange for someone to call the mother back within that same day if possible.

Conclude the interview by telling the mother when she will be contacted next and what will happen at that contact.

XI. APPENDIX

A. Occupational Codes (same as laminated sheet at each site)

B. Sample Letter To Send To Mother When Unable To Contact
By Phone

Sample Letter to Send to Mother When Unable to Contact by Phone

Mother's Name

Last Known Address

Dear _____:

Thank you for agreeing to participate in the NICHD Study of Early Child Care. We have enjoyed getting to know you and Child, and it's good to have you as part of the study.

We have been trying to contact you to find out how you and Child are getting along. Please fill out and return the enclosed card to us, or call our offices at AREA CODE/PHONE. Feel free to call us collect. Also, you can call at any time and leave a message on our answering machine. Please let us know the best way to contact you.

We hope things are going well for you and Child and we look forward to hearing from you soon.

Sincerely,

Project Staff Member

Enclosure: Return postcard